Principles of Caregiving – Student Manual
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PRINCIPLES OF CAREGIVING

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A. Principles of Caregiving Core

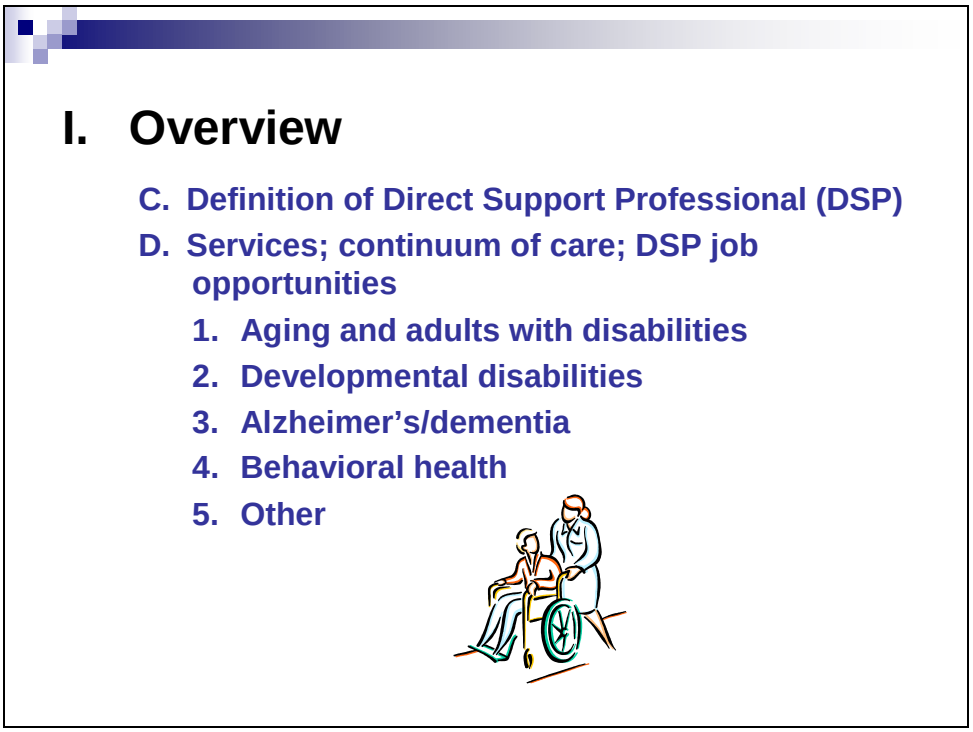
This class grew out of Governor Napolitano's taskforce on Workforce Development. The taskforce recognized the need for more training for caregivers and recommended a standardized curriculum be implemented. Historically, training was left to the discretion of individual agencies so there was a wide range in the quality of training.

Based on many, many meetings and a pilot training, this class was developed. Individuals now take this core class and have the choice of taking one or more of the modules that are being offered. The material in this core class encompasses the basic knowledge that all caregivers should know in caring for consumers.

B. Various Direct Support Professional (DSP) modules

1. Elderly/Physical Disabilities
2. Developmental Disabilities
3. Alzheimer's/Dementia
4. Behavioral Health
5. Other

These are the modules that will be available once you have taken and passed the core class. "Other" is listed because there may be more modules that are added as the need arises. Individuals must pass the core and at least one module. In fact taking and passing more than one module may make the individual more marketable, i.e. able to work in a variety of settings.



C. Definition of Direct Support Professionals (DSPs)

A Direct Support Professional (DSP) is a person who assists an elderly person or an individual with a disability with activities of daily living such as bathing and grooming and encourages attitudes and behaviors that enhance community inclusion at home, work, school, church, and other community places.

DSPs were not always considered professionals. More recently, the importance of the challenging work that DSPs perform has gained broad recognition and acknowledgement as a profession. Specific knowledge, skills, and commonly agreed-upon standards for professional conduct are what separate a "job" from a "profession." This training focuses on the skills, knowledge, and abilities that have been identified by administrators, direct support professionals, and others as critical to satisfactory job performance. Nationwide, DSPs have joined together to form a professional organization called the National Alliance for Direct Support Professionals (NADSP). The NADSP has developed a set of professional ethics (standards for professional conduct) for DSPs.

D. Services, continuum of care; DSP job opportunities

Services, continuum of care	DSP job opportunities
The **individual's home** (or a relative's home) Individual may also attend adult day services or school	• Working in the person's residence • DSP usually works alone
A **group home**, usually for a specific group of disabilities such as a group home for individuals with developmental disabilities	• Working in a home-like setting • Limited number of co-workers • DSP is responsible for assisting more than just one consumer
An **assisted living home** --Provides 24 hour care in a home-like setting for 1-10 residents --May or may not be owner occupied --An adult foster care home is owner occupied and cares for 1-4 residents	• Similar to group home • Working in a home-like setting • Limited number of co-workers • DSP is responsible for assisting more than just one consumer • Usually only up to 10 consumers and all are adults with various disabilities
An **assisted living facility** --Consumers usually live in individual apartments and pay for the services they require --Larger facilities, can be up to 100 or more units --Often the larger facilities are divided into functional units depending on how much assistance the consumer needs	• Usually care is provided in the individual's apartment • DSP usually works alone in the consumer's apartment but has co-workers working in the same complex • DSP may work for one consumer or several depending on the needs of the consumer • People will sometimes privately pay for DSP assistance above and beyond the services offered by the facility; so the DSP would be working for the individual, not the facility
A **dementia specific unit** --Similar to an assisted living facility but is specific to the care of consumers who have dementia --These units are usually locked so that consumers cannot wander away	• DSP works on the unit with other co-workers (number depends on how large the unit is) • DSP assigned to assist more than one consumer
A **skilled nursing facility** ("nursing home") --Skilled nursing care 24/7	Usually person providing hands-on assistance with ADLs is a CNA although DSP may be hired in a support position (i.e. activities or dietary)

Possible job titles for a DSP:

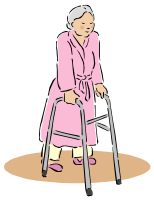
- Home care aide
- Personal care aide
- Personal care attendant
- Attendant
- Respite worker
- Companion
- Caregiver
- Care associate

Note:
Can the class think of any more titles?

I. Overview

E. Consumer-directed care

1. **History of movement**
2. **Philosophy**
3. **Benefits**



E. Consumer-directed care

Comparison of strategies in a Medical/Rehab environment versus an Independent Living Environment

	Medical/Rehab Environment	**Independent Living Environment**
Focus of care	Individual	Environment
Social	Patient, Client	Person, Consumer
Control	Professional	Consumer
Solution	Professional Intervention	Peer Support, Barrier Removal, and Advocacy
Outcomes	Maximize Assist with ADL's	Independence and inclusion
Yields	(Powerless Patient)	(Socialized Person)

1. History of Movement

History of Treatment of Individuals with Disabilities

Prehistoric Times
- Discarded
- Unworthy to feed

Middle Ages
- Possessed by evil spirits
- Caused by sins of the parents

1700-1800's
- Schools were being formed
- Braille was established

1900's
- Institutions were established for "genetic mistakes"

1930's
Hitler was striving for the "Super Race", sterilized people with hereditary disabilities. Gas chambers were first used to kill over two hundred thousand people with disabilities.
1950's
Television represented people with disabilities with a negative stereotype, "The Piety Soap Box".
March of Dimes
Muscular Dystrophy Telethon
1990's
ADA becomes law (Justin Dart is the father of the ADA)
Access to public buildings
Transportation
Telecommunications
Job opportunities

The Independent Living Movement

With origins in the U.S. civil rights and consumer movements of the late 1960s, **the Independent Living Movement grew out of the Disability Rights Movement,** which began in the 1970s. The IL Movement works at replacing the special education and rehabilitation experts' concepts of integration, normalization and rehabilitation with a new paradigm developed by people with disabilities themselves.

The first Independent Living ideologists and organizers were people with extensive disabilities. Still, the movement's message seems most popular among people whose lives depend on assistance with the activities of daily living and who, in the view of the IL Movement, are most exposed to custodial care, paternalistic attitudes and control by professionals.

2. Philosophy

The Independent Living philosophy states that people with disabilities are the best experts on their needs, and therefore they must take the initiative, individually and collectively, in designing and promoting better solutions and must organize themselves for political power. Besides de-professionalization and self-representation, the Independent Living ideology comprises de-medicalization of disability, de-institutionalization and cross-disability (i.e. inclusion in the IL Movement regardless of diagnoses).

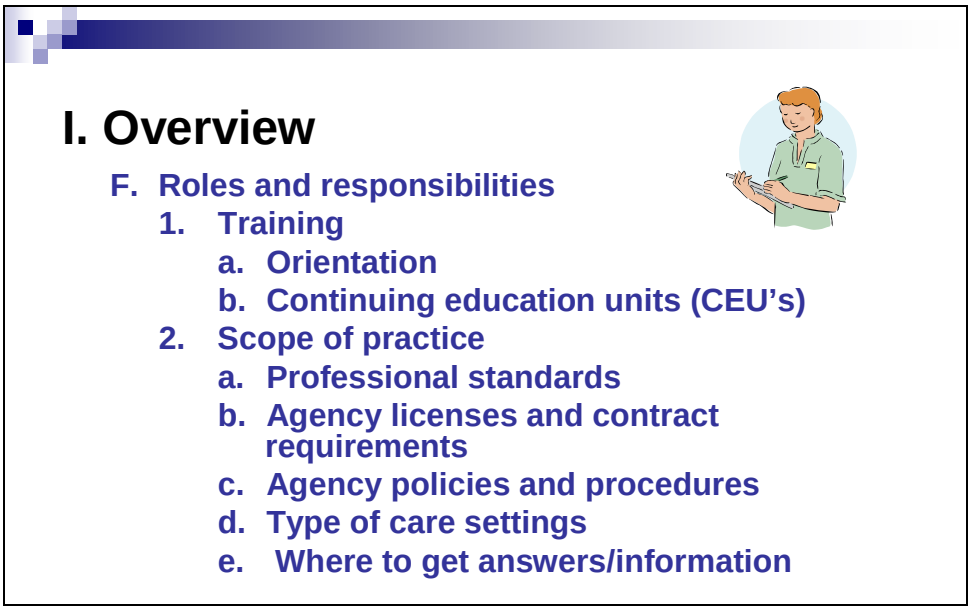
In the Independent Living philosophy, people with disabilities are primarily seen as citizens and only secondarily as consumers of healthcare, rehabilitation or social services. As citizens in democratic societies, the IL Movement claims, persons with disabilities have the same right to participation, the same range of options, degree of freedom, control and self-determination in everyday life that other citizens take for granted. Thus, IL activists demand the removal of infrastructural, institutional and attitudinal barriers and the adoption of the Universal Design principle. Depending on the individual's disability, support services such as assistive technology, income supplements or personal assistance are seen as necessary to achieve equal

opportunities. As emphasized by the IL Movement, needs assessment and service delivery must enable **users to control their services, to freely choose among competing service providers and to live with dignity in the community.**

From Wikipedia, the free encyclopedia: http://en.wikipedia.org/wiki/Independent_living

3. Benefits

a. Offers freedom of choice
b. Gives back civil rights (right to marry, right to vote, etc.)
c. Increases independence and feelings of self worth
d. Promotes health and socialization



F. Roles and responsibilities

1. Training

a. Orientation

Once a DSP is hired by an agency, he/she will be required to attend the agency's orientation even though the individual completed this course. The orientation to the agency is much more specific to the particular agency such as policies, paperwork requirements, history, job expectations, etc.

b. Continuing education units (CEUs)

Each agency will require continuing education. Behavioral health licensing dictates 24 hrs of CEUs per year. Professional standards dictate the importance of continuing education to keep abreast of changes in the field. This also expands the DSP's training and skill level to improve the delivery of quality care.

2. Scope of practice

Scope of practice refers to what an employee is allowed to do on the job. The scope may change according to the type of setting the DSP works in. However, <u>all</u> DSPs have professional standards to adhere to.

a. DSP Professional Standards

- Maintain high standard of personal health and hygiene and appearance.
- Be dependable and reliable.
- Carry out responsibilities of the job the <u>best</u> way you can—take pride in a job well done.
- Show respect for a consumer's privacy.
- Recognize and respect the right of self-determination and lifestyle.
- Keep your professional life separate from your personal life.
- Control any negative reactions to chronic disability or living conditions.

- Maintain safe conditions in the work environment.
- Do not use consumer's medications for your own health problems.
- Do not give your cell number or home number to your consumer.

b. Agency licenses and contract requirements
The scope of practice is also determined by the licenses and contract requirements where the DSP works. An example is an agency that sends workers into assisted living facilities. Those workers must adhere to the license requirements for assisted living which are different than the license requirements for adult day care.

c. Agency policies and procedures
Each agency has its own policies and procedures. What a DSP may do when working for one agency may not be the same for another agency. Example: Procedures to follow if a consumer falls.

d. Type of care settings
The scope of what a DSP should do is also based on the type of care setting. Example: Independent apartment versus a group home.

e. Where to get answers/information
In summary, there can be differences in the scope of practice related to licensing and agency policies, etc. In order to know job expectations and responsibilities a DSP should attend agency orientation, in-services, contact their supervisor and read their job descriptions. If questions arise, contact the supervisor.

It is better to ask questions than to do something that may be unsafe, cause for disciplinary action, and/or a liability issue.

PRINCIPLES OF CAREGIVING

SECTION II - LEGAL & ETHICAL ISSUES

II. Legal and Ethical Issues

A. Definitions
B. Distinction between law and ethics
C. Primary legal responsibilities
D. Avoiding legal action
E. Ethical principles
F. Consumer rights
G. DSP rights

A. Legal terms—Definitions

1. **Abandonment** is when a family or agency leaves an individual without care or support.
2. **Assault** takes place when an individual intentionally attempts or threatens to touch another individual in a harmful or offensive manner without their consent.
3. **Battery** takes place when an individual harmfully or offensively touches another individual without their consent.
4. **False imprisonment** takes place when you intentionally restrict an individual's freedom to leave a space.
5. **Invasion of privacy** is revealing personal or private information without an individual's consent.
6. **Liability** refers to the degree to which you or your employer will be held financially responsible for damages resulting from your negligence.
7. **Malpractice** is a failure to use reasonable judgment when applying your professional knowledge.
8. **Negligence** is when a personal injury or property damage is caused by your act or your failure to act when you have a duty to act.

B. Distinction between law and ethics

1. **Law**: code or system of laws
2. **Ethics**: a system of moral values; a set of principles of conscientious conduct
   Some laws are also ethical (e.g., abuse laws); some are not (e.g., speeding); but not all ethical principles are laws (e.g., being honest)

C. Primary legal responsibilities—

To avoid legal action for you and the company you work for.

D. Avoiding legal action

1. **Keep personal information confidential**: Do not discuss confidential information with others except your supervisor or other colleagues who are directly involved with the consumer's care. Confidential information may include medical, financial, or family issues.
2. **Only perform work assigned**. If you perform a task that was not assigned by your supervisor, you become liable for those actions.
3. **Do not do less work than assigned**: When you fail or forget to do all the tasks assigned, you may put your consumer at risk. As a result of your failure to act, you might be found negligent.
4. **Avoid doing careless or low-quality work**: Performing tasks carelessly might make you liable for the damages or injuries that result.

E. Ethical principles

1. **Confidentiality**: do not discuss confidential information with others except your supervisor or other colleagues that are directly involved with the consumer's care. Confidential information may include medical, financial or family issues.
2. **Honesty:** do not be afraid to politely say "no" to a task you are not assigned to do. Also, do not be afraid to admit that you do not know an answer to a question or how to do a task. Never steal, take a consumer's possessions, or falsify documents or reports.
3. **Respect:** a consumer's religious or personal beliefs and values will possibly differ from yours. You should respect those differences.
4. **Reliability:** arrive for assignments on time. Always finish your shift, even if a consumer is being difficult or the workload is too difficult. You can address those problems with the supervisor after you have finished your shift.
5. You should not take gifts or tips.
6. If you discover a case of abuse, report it.
7. Never have sexual relations with a consumer or other person in the household.
8. Do not change the consumer's care plan without consulting your supervisor.

F. Consumer rights

Consumers have the right to:

1. Considerate and respectful treatment and care.
2. Not be abused emotionally, sexually, financially, or physically
3. Design their treatment or care plan, decide how their services will be provided, and who will deliver those services (including requesting a change of caregiver)
4. Receipts or statements for their fee-based service
5. Refuse treatment
6. File a complaint with the agency
7. Privacy and confidential handling of their personal information

G. DSP rights

Providers have the right to:

1. File a complaint without the fear of retaliation.
2. Not to be abused emotionally, sexually, financially, or physically.

3. Suggest changes to a consumer's care plan in order to make delivery of care more efficient and less stressful.
4. Be informed when a consumer files a complaint against him or her.
5. A confidential investigation, a fair hearing, and the outcome when addressing complaints against him or her.
6. Receive timely payment for services including salary and mileage, where appropriate
7. Work in a safe environment

II. Legal and Ethical Issues

- H. Confidentiality
  - 1. General guidelines
  - 2. HIPAA requirements
- I. Adult and child abuse
  - 1. Definitions and examples
  - 2. Risk factors
  - 3. Signs and symptoms
  - 4. Prevention
  - 5. Reporting requirements
  - 6. Legal penalties
  - 7. Scenarios
- J. Other

H. Confidentiality

(Based on the HIPAA training from the Foundation for Senior Living)

1. General guidelines

2. HIPAA requirements

WHAT IS HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is a law that keeps the identifiable health information about our consumers confidential. It includes what must be done to maintain this privacy and punishments for anyone caught violating consumer privacy. The Office of Civil Rights of the U.S. Department of Health and Human Services is the agency authorized to enforce HIPAA's privacy regulations. The regulations took effect on April 14, 2003.

WHAT IS CONFIDENTIAL?

All information about our consumers is considered private or "confidential", whether written on paper, saved on a computer, or spoken aloud. This includes their name, address, age, Social Security number, and any other personal information. It also includes the reason the consumer is sick, the treatments and medications he/she receives, caregiver information, any information about past health conditions, future health plans, and why the consumer is open to services.

Spoken communication runs the gamut from conducting consumer interviews, paging consumers, whispering in corridors, to talking on telephones. Written communication includes the hard copy of the medical record, letters, forms, or any paper exchange of information. Electronic communication includes computerized medical records, electronic billing and e-mail.

If you reveal any of this information to someone who does not "need to know" it, you have violated a consumer's confidentiality, and you have broken the law.

WHAT ARE THE CONSEQUENCES OF BREAKING THE LAW?

The consequences will vary, based on the severity of the violation, whether the violation was intentional or unintentional, or whether the violation indicated a pattern or practice of improper use or disclosure of identifiable health information. Talk to your supervisor about the disciplinary action.

Agencies may be fined by the government if they are found to be in non-compliance with HIPAA regulations. Agencies and their employees can receive civil penalties of a $100 fine per violation per person, up to $25,000 for the same violation. Agencies and their employees can also receive criminal penalties: up to a $50,000 fine and 1 year in prison, or both, for anyone who knowingly releases information; up to a $100,000 fine, 5 years in prison, or both, for releasing information under false pretenses, and up to a $250,000 fine, 10 years in prison, or both, for using information for commercial or personal gain or malicious harm.

WHY ARE PRIVACY AND CONFIDENTIALITY IMPORTANT?

Our consumers need to trust us before they will feel comfortable enough to share any personal information with us. In order for us to provide quality care, we must have this information. They must know that whatever they tell us will be kept private and limited to those who need the information for treatment, payment, and health care operations. Health care operations are activities such as conducting medical record reviews, training staff, and state inspections. Our consumers will have control over who will be told any personal information about them with or without their written permission.

WHAT IS THE "NEED TO KNOW" RULE?

This rule is really common sense. If you need to see consumer information to perform your job, you are allowed to do so. But, you may not need to see all the information about every consumer. You should only have access to what you need to in order to perform your job. There may also be occasions when you will have access to confidential information that you don't need for your work. For example, you may see information on whiteboards or sign-in sheets. You must keep this information confidential. There's no doubt that you will overhear private health information as you do your day-to-day work. As long as you keep it to yourself, you have nothing to worry about. In the course of doing your job, you may also find that consumers speak to you about their condition. Although there's nothing wrong with this, you must remember that they trust you to keep what they tell you confidential. Do not pass it on unless it involves information the professional staff needs to know to do their jobs. Tell the consumer that you will be sharing it with the professional staff or encourage them to tell the information themselves.

So, before looking at a consumer's health information, ask yourself one simple question, "Do I need to know this to do my job?" If the answer is no, stop. If the answer is yes, you have nothing to worry about.

WHO IS RESPONSIBLE FOR HIPAA COMPLIANCE?

HIPAA mandates that each agency have a Privacy Officer to make sure that no one breaks the privacy rule. He/she is responsible for coming up with the organization's privacy policies and enforcing them. If you spot someone breaking the rules, report him/her either to your supervisor or directly to the Privacy Officer. You should feel comfortable going to either of them with questions about how to follow the privacy rules without fear of retaliation.

WHAT ARE THE CONSUMER'S HIPAA RIGHTS?

Each consumer has certain rights under the HIPAA regulations. Unless the information is needed for treatment, payment, and health care operations, we cannot release any information without a written authorization from the consumer. The consumer must also give you verbal/written permission to discuss information with a family member. This permission should then be documented in the consumer's chart. Release of psychotherapy notes always needs written authorization. The consumer also has the following rights:

- To inspect and copy his/her medical record
- To amend the medical record if he/she feels it is incorrect
- To an accounting of all disclosures that were made, and to whom, except those necessary for treatment, payment, or health care operations
- To restrict or limit use or access to medical information by others
- To confidential communications in the manner he/she requests
- To receive a copy of the agency's Notice of Privacy Practices

All of the rights listed above must be requested, in writing, on the agency's approved forms designed for these specific purposes. Every employee must be aware of the contents of the Notice of Privacy Practices.

If the consumer feels the agency or its staff has not followed the HIPAA regulations, the consumer can make a formal, written complaint to the agency's Privacy Officer or to the Department of Health and Human Services, Washington, DC.

WHAT SHOULD I DO IF I KNOW OF A BREACH OF CONFIDENTIALITY?

The agency expects everyone to follow the privacy and confidentiality policies, but it recognizes there may be times when the policy is being abused. You are expected to report violations or suspected violations to the Privacy Officer. You do not have to fear any retaliation if you report a privacy violation, as this is considered one of your job responsibilities.

WHAT ARE WAYS TO PROTECT CONFIDENTIALITY?

Oral Communications:

- Watch what you say, where you say it, and to whom
- Speak in a quiet voice during the sharing of information
- Close doors when discussing private information
- Do not talk about health information matters in front of others
- Avoid paging consumers using information that could reveal their health issues
- If someone asks you a question involving personal information, make sure that person has a "need to know" before answering

Telephone Communications:

- Never leave personal health information on an answering machine regarding a consumer's conditions/test results/etc.
- If you are leaving a message on an answering machine/voice mail, only leave the name of the person calling and the agency's telephone number with your contact phone number and request a call back.
- Do not leave messages with anyone other than the consumer or a responsible party
- Verify the person requesting information if you are unsure of the source of the telephone call

Medical Records:

- Make sure medical records are viewed only by those who need to see them
- Store them in an area not easily accessible to non-essential staff/others
- Do not leave medical records lying around unattended or in an area where others can see them
- Return the medical record to its appropriate location when finished viewing it

Trash:

- **Shred all papers containing personal health information when they are discarded**
- Put trash cans and shredders as close as possible to fax machines and desks where personal health information is used
- If you see un-shredded paper discarded in a trash can, remove it and bring it to your supervisor

Fax Transmissions:

- Fax machines should be in a secure area
- Do not leave papers containing private health information on the fax machine unattended
- Pre-program frequently faxed numbers into the fax machine to reduce dialing errors
- Periodically check on the pre-programmed numbers to make sure they are still correct
- If possible, notify the receiver when you are sending a fax
- Try to verify the legitimacy of fax requests if the requester is unknown to you
- Have a fax cover sheet with a statement that the fax contains protected health information, re-disclosure is prohibited, and what to do if the wrong person gets it

Computers:

- Develop a personal password which is not a guessable name and change it as instructed
- Never share your password or write down your password except with your supervisor
- Position your monitor so it is not facing where someone could view identifiable health information
- Never leave a computer unattended without logging off
- Shut down all computers and lock the doors when no staff members are in the room
- All e-mails sent, which contain identifiable health information, will be encrypted and the sender/receiver should be authenticated
- Double-check the address before sending any e-mail
- Never remove computer equipment, disks, or software from your workplace without the Privacy Officer's permission
- Never discard computer equipment or disks in the trash without the Privacy Officer's permission

I. Adult and Child Abuse

1. Definition

Adult and child abuse refers to any form of maltreatment of a person by a caregiver, family member, spouse, or friend. Categories of abuse include:

a. Abuse

Intentional infliction of physical harm or unreasonable confinement

b. Sexual abuse or sexual assault

Sexual contact with any person incapable of giving consent or through force or coercion

c. Neglect

Failing to provide a person food, water, clothing, medicine, medical services, shelter (unsafe or hazardous environments), cooling, heating or other services necessary to maintain minimum physical or mental health. For children this also applies to parents leaving a child with no one to care for him/her or leaving a child with a caretaker and not returning or making other arrangements for his/her care.

d. Financial exploitation

The improper or unauthorized use of a person's funds, property, or assets. This includes forgery, stealing money or possessions, or tricking a person into signing documents that transfer funds, property, or assets. For children this also includes using a child for material gain including forcing a child to panhandle, steal or perform other illegal or involuntary activities.

e. Emotional abuse

Psychological abuse such as name-calling, insults, threats, and intimidation

2. Risk factors

a. Adult abuse

- Previous incidents of domestic violence by spouse.
- Financial dependency on the adult by the abuser.
- Mental illness of abuser.
- Adult children living with older parent
- Abuser isolates adult to prevent the abuse from being discovered.

b. Child abuse

- Child living in area with high poverty, unemployment or crime rates
- Child has physical and/or mental disability
- Abuser has history of physical or sexual abuse as a child
- Abuser has low self-esteem, abuses drugs or alcohol, or suffers from depression or mental illness

3. Signs

a. Adult abuse

- Physical: bruises, broken bones, cuts or other untreated injuries in various stages of healing.
- Sexual: bruises around breast or genital area; signs of sexually transmitted diseases (STDs).

- Emotional: adult is upset or agitated, withdrawn, non-communicative, or paranoid.
- Neglect: dehydration, malnutrition, pressure ulcers, poor personal hygiene, and unsafe or unsanitary living conditions.
- Financial: unusual banking activity; missing financial statements or other personal affects such as jewelry; signatures on checks that do not match adult's signature.

b. Child Abuse

- Physical: bruises, broken bones, cuts or other untreated injuries in various stages of healing.
- Sexual: bruises around breast or genital area; signs of sexually transmitted diseases (STDs), pregnancy
- Emotional: eating disorders; speech disorders; developmental delay; cruel behavior; behavioral extremes
- Neglect: poor hygiene; absenteeism; hunger; tiredness; begging for or collecting leftovers; assuming adult responsibilities; reporting no caretaker at home

4. Prevention

a. Community awareness
b. Public and professional education
c. Caregiver support groups
d. Stress management training
e. Respite care/In-home services
f. **The Parent Assistance Program** is a service designed to help parent or guardians. This program, operating through the Administrative Office of the Courts, provides a 24-hour toll-free hotline to assist parents with their questions and concerns about CPS. Through the hotline, parents may obtain information about legal assistance, the juvenile court system and their legal rights and responsibilities. Trained hotline staff may also provide crisis counseling and referrals to appropriate agencies or individuals. To contact the parent assistance program call:

Phoenix: (602) 542-9580 Statewide toll-free: 1-800-732-8193

5. Reporting requirements (Mandatory reporting)

a. All persons responsible for the care of an incapacitated or vulnerable adult or child **have a duty to report** suspected abuse and neglect.

b. Reports must be made immediately (by phone or in person) to Adult Protective Services or Child Protective Services (depending on the person's age) or to the police. **Failure to report is a misdemeanor.**

- If the individual is in immediate danger, call 911.
- If the abuse is not life-threatening, report it to your Supervisor who will assist you in making the report to either of the 24-hour a day statewide reporting lines:
  - Adult Protective Services: 1-877-SOS-ADULT (1-877-767-2385)
  - Child Protective Services: 1-888-SOS-CHILD (1-888-767-2445)

Immunity (ARS 46-453)

All persons reporting are immune from any civil or criminal liability if the report does not involve any malicious misrepresentation.

6. Legal penalties

Any person who has been employed to provide care to an incapacitated or vulnerable adult or child and who causes or permits the person's life to be endangered or his/her health to be injured or endangered by neglect can be found guilty of a felony.

An individual who is found guilty of a felony will not only face jail time but a felony conviction also limits the type of jobs the individual can hold in the future (i.e. convicted felons are unable to work in most healthcare or educational systems).

7. Scenarios

A. You are assigned to provide personal care services for Mabel including a shower. Mabel is living in a poorly maintained home. She has a son who pays her bills and stops by a few times a week. When you arrive at Mabel's home, Mabel is complaining of being cold. The thermostat for the heater registers 60 degrees. You talk to Mabel's son who tells you that the furnace is broken but, "it is okay because I have just given Mom some blankets. She doesn't need it any warmer."

   What would you do?

B. You are assigned to provide respite care for Jimmy who is a 10-year-old boy with autism. When you arrive at Jimmy's home, Jimmy is outside wandering in the street. No one is at home but Jimmy's 10-year-old brother who is watching TV.

   What would you do?

Two good resources for reference materials are Child Protective Services for a booklet on child abuse and the Area Agency on Aging, Region One for the Elder Abuse booklet.

PRINCIPLES OF CAREGIVING

SECTION III - CULTURAL COMPETENCY

III. Cultural Competency

- A. Definitions
- B. Awareness and differences
  1. Perceptions
  2. Cross-cultural communication
  3. Communication
     - a. Do's
     - b. Don'ts

A. Definitions

1. Culture – Socially transmitted (as opposed to genetically transmitted) behavior patterns, arts, beliefs, communications, actions, customs, and values of racial, ethnic, religious, or social groups
2. Cultural Competency
   a. Clinical Based Definition – Cultural competence is a set of behaviors, attitude, and policies that come together in a system, agency or among professionals that enable them to work effectively in cross-cultural situations. (Cross et al,1989).
   b. Cultural Competency is the genuine sensitivity and respect given to people regardless of their ethnicity, race, language, culture or national origin. (E. Calahan, 2003)
3. Cultural Knowledge – Familiarization with selected characteristics, history, values, belief systems, and behavior of the members of another ethnic group (Adam, 1995).
4. Cultural Awareness – Developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others.
5. Cultural Sensitivity – Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences (National Maternal and Child Health Center on Cultural Competency, 1997).
6. Cross Cultural – Interaction between individuals from different cultures.
7. Ethnicity – Belonging to a common group with shared heritage, often linked by race, nationality, and language
8. Race – a socially defined population that is derived from distinguishable physical characteristics that are genetically determined.

The Cultural Competency Continuum

1. Fear – Others are viewed with apprehension and contact is avoided.
2. Denial – The existence of the other group is denied. This belief may reflect either physical or social isolation from people of different cultural backgrounds
3. Superiority – The other group exists but is considered inferior.
4. Minimization – An individual acknowledges cultural differences but trivializes them believing human similarities far outweigh any differences.
5. Acceptance – Differences are appreciated, noted and valued.
6. Adaptation – Individuals develop and improve skills for interacting and communicating with people of other cultures—the ability to look at the world with different eyes.
7. Integration – Individuals in this stage not only value a variety of cultures, but are constantly defining their own identity and evaluating behavior and values in contrast to and in concert with a multitude of cultures.

A culturally competent person acknowledges and values diversity and accommodates differences by seeking a common vision (i.e. the need for assistance). **Diversity is viewed as a <u>strength</u>**. Cultural competency encompasses more than race, gender, and ethnicity … it includes all those *differences* that make us unique. With adequate time, commitment, learning, and action, people and organizations can change, grow, improve … to become more *culturally competent.*

B. Awareness and differences

Cultural awareness and sensitivity are an important part of providing care to the people being served by DSPs. We need to respect other cultures and try to learn more about the different cultures for a better understanding of the individuals being served.

Examples of some culture differences:

1. Native American Culture
   - Usually want a DSP from their own tribe
   - Believe in non-traditional medicine
2. Asian Culture
   - Prefer more space between speaker and listener
   - Limited contact, prefer not to be hugged, back slapping, etc.
3. Latin Culture
   - Comfortable with close conversational distance
   - More expressive
4. East Indian
   - Believe the head is fragile and should not be touched
5. Muslim Culture
   - Woman will not shake the hand of a male

Examples of some innocent gestures that could be mistaken as being offensive:

1. Use of the left hand to touch or hand something to a person. Some cultures use their left hand for personal hygiene and think of it as being unclean.
2. Nodding the head up and down is considered a sign of understanding and agreeing, but among other cultures it is simply saying, “I hear you are speaking”.
3. Strong eye contact can be appreciated by one culture but by another it could be a sign of disrespect.

1. Perceptions

Specifically, this part of the training addresses two key questions or concepts:

a. How has my experience and my culture impacted how I see and respond to others?
b. How do my perceptions of and response to others impact them?

Let's begin by talking about cultural preconceptions and stereotypes….

a. No one is born with opinions or biases, rather they are learned.
b. When children learn about the world, they learn both information and misinformation about people who are different from them and their families by virtue of gender, race, religion, sexual orientation, class, or in other ways.
c. Some of this information is about stereotyping. This is where stereotyping takes root.

People we learned from were simply passing onto us messages that had been handed down to them. Besides our family and friends, we received some of the messages from society through the media and our everyday surroundings such as television, textbooks, advertisements, etc. Sometimes, the messages were overt and sometimes they were subtle.

Examples:
a. My mother would say, "Lock the door" when driving through a certain neighborhood
b. Adults say, "Change the radio station" when certain topics were being discussed.

These influences in our lives basically have the effect of putting us on "automatic". When we encounter certain situations or people, we automatically respond (usually due to fear) rather than rationally thinking through the situation.

This process of being on automatic is stereotyping.
As adults, most of us are still on automatic; we still form new "mental tapes" and respond with knee-jerk reactions to people who are different from us. Stereotyping is very difficult to undo. **We all do it!** Freeing ourselves of the tendency to stereotype allows us to work more positively and effectively with consumers and others who are culturally different from ourselves.

Through self-awareness and sustained efforts, it is possible to control the automatic, become conscious of our reactions to difference, make choices about how we wish to behave, and begin to respond to differences in a clear-headed, rational manner without fear and apprehension. We may not be able to undo our stereotypes, but we can begin to manage them (to become more culturally competent).

Example: You walk into a home and you see the home is quite dirty and cluttered. Your first inclination is to decline the position. You talk with your supervisor and she informs you that the consumer's son lived there for two months, but has since moved. You now are in a position to really make a difference in this consumer's life.

Awareness is the key.

2. Cross-cultural communication

To work effectively in a culturally diverse environment, we need to have an understanding of some of the potential barriers to effective cross-cultural communication and interaction.

When communication between people breaks down, it is frustrating and often appears to be due to a difference in communication style. However, the more fundamental cause is often a difference in values, which are shaped by culture and experiences.

What are some examples of communication styles that are influenced or shaped by our individual culture and experiences? Examples are tone of voice, regional accents, gestures, affect, topics, physical space, etc.

a. Assumed similarity – We assume that words and gestures have a set meaning even if we speak the same language.
b. Non-verbal communication – Approximately 70% to 90% of our communication is affected by non-verbal cues through smiling, silence, gestures, nodding, eye contact, body language, and touch. Because non-verbal cues mean different things to different cultures, we need to be cautious of the interpretations we attach to these behaviors. Example: Not making eye contact can mean passive, and untrustworthy, while making eye contact may be seen as rude and aggressive.
c. Verbal language – The most obvious barrier. Nuances like slang and idioms "run that by me," "cut the check." –technical jargon like Fed Ex, tubes tied, and accents. Talking emotionally may be considered aggressive, while talking slowly, may be considered unmotivated.

We benefit if we develop strategies to address the stumbling blocks to cross-cultural communication we just talked about. Some important elements to bridging some of the barriers are:

a. Self-awareness…we should be aware of our own assumptions and preconceptions about other cultures, as well as our own comfort level with different styles of communication.
b. We can decide consciously not to act on our stereotypes and assumptions.
c. We can make an effort to maintain open-mindedness and objectivity and avoid using our own cultural values or beliefs as a standard by which to judge others.
d. Listen with RESPECT, even though the other person may have different values from you.
e. Increase your culture-specific awareness without stereotyping. Watch for cultural behavior and communication patterns.
f. Treat each person uniquely. Each individual is different and may not fit a particular pattern for a group.
g. Seek out information. Feel free to ask/observe.
h. Tolerate ambiguity – Situations may just not be as clear cut as you would like them. It's OK.

3. Communication

a. **Communication Do's**

- Learn and use the correct pronunciation of a person's name
- Give examples to illustrate a point
- Look at the situation from the other person's perspective
- Simplify or rephrase what is said
- Use language that is inclusive
- Pause between sentences
- Ask for clarification
- Remain aware of biases and assumptions
- Be patient

b. **Communication Don'ts**

- Pretend to understand
- Always assume that you are being understood
- Rush or shout
- Laugh at misused words or phrases
- Overuse idioms and slang
- Assume that using first names is appropriate
- Assume that limited language proficiency means limited intelligence

In Summary:

There are many cultural differences with the people being served. The best way to work through these differences is communicating with your consumers and learning from them about their customs, traditions, etc. and how that impacts the assistance you are providing.

- Take the time to learn about an individual's needs, strengths, and preferences.
- Do not assume that you know what is best.
- The manner in which you support individuals should reflect their needs, strengths, and preferences, not yours (i.e., giving choices and showing respect).

The old rule was the Golden Rule: Treat others the way you would want to be treated.
The new rule is the Platinum Rule: Treat others as <u>they</u> want to be treated.

What do you do when you are preparing to provide care to a person from a culture other than yours?

- Do not be judgmental.
- Talk to the person (or family members) being served about his/her customs, so you do not unintentionally offend him/her.
- Avoid body language that can be offensive
- Avoid clothing that can be offensive

Resource: Adapted with permission from "Introduction to Cultural Competency", Value Options 2004

For more information on cultural competencies:
http://www.med.umich.edu/multicultural/ccp/bmhg.htm%20

PRINCIPLES OF CAREGIVING

SECTION IV - COMMUNICATION

IV. Communication

- A. Components of effective communication
- B. Verbal
- C. Nonverbal
- D. Communication styles
  1. Aggressive
  2. Passive
  3. Assertive

A. Components of effective communication

Communication in homecare is the link between you, the consumer, and the agency. Sharing accurate information and observations with family and the agency improves the care a consumer receives.

Effective communication happens when the intended meaning of the sender and the perceived meaning of the receiver are virtually the same.

Very simply, there are two major components to effective communication — speaking and listening. Listening involves not just hearing the message, but the ability to understand, remember, evaluate and respond.

B. Verbal

Verbal communication not only includes oral and spoken communication but may also include sign language and writing as forms of verbal communication.

Communication with consumers is not the same as communicating with friends. Remember, your tone of voice can send different messages.

Example: “Good Morning” (Use different tones of voice)

C. Nonverbal

Nonverbal communication can be divided into several categories: facial expressions, head movements, hand and arm gestures, physical space, touching, eye contact, and physical postures.

It is believed that 90% of communication is nonverbal and only 10% is verbal.

Have you ever visited a country and didn't speak the language? How important was non-verbal communication?

Facial expressions – What they can mean in different cultures

- Although smiling is an expression of happiness in most cultures, it can also signify other emotions. Some Chinese, for example may smile when they are discussing something sad or uncomfortable.
- Winking has very different connotations in different cultures. In some Latin American cultures, winking is a romantic or sexual invitation. In Nigeria, Yorubas may wink at their children if they want them to leave the room. Many Chinese consider winking to be rude.
- In Hong Kong, it is important not to blink one's eyes conspicuously, as this may be seen as a sign of disrespect and boredom.
- Some Filipinos will point to an object by shifting their eyes toward it or pursing their lips and point with their mouth, rather than using their hands.
- Some Venezuelans may use their lips to point at something, because pointing with a finger is impolite.
- Expressions of pain or discomfort such as crying are also specific to various cultures; some cultures may value a stoic affect while others may encourage a more emotive state. Expressions of pain or discomfort are also learned from one's family illness experiences, expressions, and idioms of distress.

When verbal and non-verbal communication are combined, a stronger message can be sent or a completely different message is sent if the verbal and nonverbal do not agree.

Example #1 While asking your consumer to sign your time sheet, you hold the timesheet and pen in your hand.

Example #2 You ask your consumer, How are you today?" and she replies, "I'm okay," but she is sobbing into a tissue. Two different messages are being sent.

D. Communication styles

The communication process involves the:
1. Sender
2. Receiver
3. The message
4. Feedback

The goal of communication is the acceptance of the sender's message by the receiver. If the receiver understands the meaning of a message and perceives it the same as the sender, the goal of communication is achieved. The sender gets input as to how the receiver perceived the message via feedback from the receiver. If the feedback never comes or if the feedback is not what the sender expects, communication is ineffective.

The main types of communication styles are:

1. **Aggressive**
   Likely to attack, showing a readiness or having a tendency to attack
2. **Passive**
   Tending not to participate actively, and usually letting others make the decisions
3. **Assertive**
   Confident in stating a position or claim

Or stated another way:

Aggressive: Meeting needs of self and not of others
Passive: Meeting needs of others and not self
Assertive: Meeting need of both others and self

Give examples of each of the following resolution categories:

Competitive: High on **aggressive**, low on passive (meets needs of self)

Accommodative: Low on aggressive, high on **passive**

Avoiding: Low on aggressive, low on passive (meets needs of others)

Collaborative: High on aggressive, high on passive (meets everyone's needs) – **ASSERTIVE**

Compromising: In the middle (everyone gets some needs met, everyone gives up some needs) - **ASSERTIVE**

ASSERTIVENESS is a WIN/WIN situation!

WHAT IS AGGRESSIVE COMMUNICATION?

May be physical, nonverbal (if looks could kill, scorn, ridicule, disgust, disbelief, scorn, snorts); verbal (insults, sarcasm, put downs); used to humiliate or demean another person (profanity, blaming).

Why People Behave in an Aggressive Way:

- They anticipate being attacked and overreact aggressively.
- They are initially non-assertive. Their anger builds until they explode.
- They have been reinforced for aggressive behavior. It got them attention and/or what they wanted.
- They never learned the skills for being assertive.
- They do not know how to appropriately communicate their wants and needs to others.
- They were socialized to win, be in charge, be competitive, achieve, and be top dog.

Consequences:

- They get their own way but often alienate others.
- They are often lonely and feel rejected.
- They receive little respect from others.
- They may develop high blood pressure, ulcers, have a heart attack, or other related ailments.

WHAT IS PASSIVE COMMUNICATION?

"Not resisting" or "not acting", derived from the Latin word "to suffer", which is often the result of passive behavior. A verbally passive person "keeps quiet", withholds feedback. Risks communication and relationships because when you withhold needed information and create an atmosphere of uncertainty, the other person never really knows what you think or feel (no one is a mind reader); leads to misunderstandings, strained relationships and suffering.

Why People Behave in a Passive Way:

- They believe they have no rights
- They mistake being assertive as being aggressive
- They fear negative consequences (someone being angry, rejecting, or disapproving of them)
- They do not know how to communicate their wants and needs to others, and assume others should know these.
- They were socialized to always be compliant, accepting, accommodating, non-demanding, selfless.

Consequences:

- They avoid conflict but often appease others
- They lose self esteem
- They develop a growing sense of anger and hurt.
- They may develop headaches, ulcers, backaches, depression, and other symptoms.

WHAT IS PASSIVE AGGRESSIVE COMMUNICATION?

More subtle, underhanded, manipulating, procrastinating, forgetting, pouting, silent treatment, manipulative tears

WHAT IS ASSERTIVE COMMUNICATION?

1. It is **respectful** of yourself and others
2. It **recognizes your needs as well as others**—it is not a doormat!
3. It is **constructive, honest, open** direct communication
    - you have options
    - proactive
    - values self and others
    - stand up for yourself without excessive anxiety
    - accept your own and other's limitations

TIPS FOR EFFECTIVE COMMUNICATION:

1. Use “I” messages instead of “You” messages
   FEELINGS—OWN THEM
   - No one can make me feel something
   - Feelings belong to you/me
   - Internal reactions
   - Different people respond with different emotions to the same situation
   - Feelings are not right or wrong—they just are
2. Stick to the point/issue at hand—don’t add on “and another thing…”
3. Turn negative into a positive
4. Set Limits
5. Do not react when you feel your emotions are rising:
   - Listen first
   - Speak in “I” and “I want”
   - Own feelings
   - Do not act like they are acting, do not jump in the battle

IV. Communication

E. Barriers and interventions

1. Inadequate listening skills
2. Attitude
   a. DSP
   b. Consumer
   c. Family
   d. Others

E. Barriers and interventions

1. Inadequate listening skills

Steps to improve your listening skills

a. Be quiet. Pay attention to what the other person is saying.
b. Stop all other activities. Focus on the speaker
c. Listen to the entire message.
d. Do not interrupt the speaker. Let the speaker finish, even if it takes a long time.
e. Do not try to think of a response while the person is speaking.
f. Do not finish sentences that the speaker begins.
g. Listen for feelings
h. Ask questions that encourages the speaker to continue-**Open ended questions**

- Closed ended questions are answered by "yes" or "no"
- Opened ended questions are responded to with more details

Closed Ended Question	Open Ended Question
"Did you eat breakfast today?"	**"What did you have for breakfast today?"**
"Are you feeling okay today?"	**"Could you describe how you are feeling today?**

Barriers or behaviors to avoid

a. Giving advice
b. Making judgment
c. Giving false reassurances about your consumer's physical or emotional condition
d. Focusing on yourself
e. Discussing your own problems or concerns
f. Discussing topics that are controversial such as religion and politics
g. Using clichés or platitudes (i.e. "Absence makes the heart grow fonder")

2. Attitude

a. DSP
b. Consumer
c. Family
d. Others

Attitudes influence our communication in three ways. Attitudes toward ourselves determine how we conduct ourselves when we transmit messages to others. If we have a favorable self-attitude, the receivers will note our self-confidence. If we have an unfavorable self-attitude, the receivers will note our uneasiness. However, if our favorable self-attitude is too strong, we tend to become brash and overbearing, and our communication loses much of its effect with the receiver.

Attitude toward the receiver or the receiver's attitude toward the sender also influences our communication. Our messages are likely to be very different when communicating the same content to someone we like and then to someone we dislike. We also structure our messages differently when talking to someone in a higher position than ours, in the same position, or in a lower position, regardless of whether we like them or not.

The message may be the same but how you deliver the message may affect how the message is perceived (i.e., a superior, controlling, condescending attitude)

Scenarios:

How would you respond (communicate feedback) in these situations?

a. Consumer: “That is not how my other worker folded my laundry!”

b. Consumer’s mother: “I don’t care what they told you at the office. I need to have you here by noon.”

IV. Communication

E. Barriers and interventions (cont'd)

3. Physical disability

a. Visual impairment

b. Hearing impairment

c. Wheelchair user

d. Other

4. Emotional/mental health impairment

5. Cognitive/memory impairment

E. Barriers and interventions (cont'd)

3. Physical disability

- communicating with individuals with disabilities such as:

a. Vision impairment

- It is appropriate to offer your help if you think it is needed but don't be surprised if the person would rather do it himself.
- If you are uncertain how to help, ask the one who needs assistance
- When addressing a person who is blind, it is helpful to call them by name or touch them gently on the arm.
- Do not touch their guide dog.
- Let the person hold onto you versus you holding them.
- When walking into a room, identify yourself.

b. Hearing impairment

- If necessary, get the person's attention with a wave of the hand, a tap on the shoulder, or other signal.
- Speak clearly and slowly, but without exaggerating your lip movements or shouting (with shouting sound may be distorted).
- Give the person time to understand and respond
- Be flexible in your language. If the person experiences difficulty understanding what you are saying, rephrase your statement rather than repeating. If difficulty persists, write it down.
- Keep background noise such as radios, TV, and others who are talking at a minimum
- Place yourself facing the light source and keep hands and food away from your face.
- Look directly at the person and speak expressively.

- When an interpreter accompanies a person, direct your remarks to the person rather than to the interpreter.
- Encourage the person to socialize since some people with a hearing impairment tend to isolate.
- Use Voice-to-TTY/PC: 1-800-842-4681(Arizona Relay Service) is designed for people who live or work in Arizona and either use a TTY/PC or want to communicate with someone who does.
- Maintain amplifier/hearing aids

c. Wheelchair user

A Guide to Wheelchair Etiquette

a. **Ask Permission.** Always ask the person if he or she would like assistance before you help. It may be necessary for the person to give you some instructions. An unexpected push could throw the person off balance
b. **Be respectful.** A person's wheelchair is part of his or her body space and should be treated with respect. Don't hang or lean on it unless you have the person's permission. When a person transfers out of the wheelchair to a chair, toilet, car, or other object, do not move the wheelchair out of reaching distance.
c. **Speak Directly.** Be careful not to exclude the person from conversations. Speak directly to the person and if the conversation lasts more than a few minutes, sit down or kneel to get yourself on the same plane as the person in the wheelchair. Also, don't be tempted to pat a person in a wheelchair on the head as it is a degrading gesture.
d. **Give Clear Instruction.** When giving instructions to a person in a wheelchair, be sure to include distance, weather conditions, and physical obstacles which may hinder their travel.
e. **Act Natural.** It is okay to use expressions like "running along" when speaking to a person in a wheelchair. It is likely the person expresses things the same way.
f. **Wheelchair Use Doesn't Mean Confinement.** Be Aware that persons who use wheelchairs are not confined to them.
g. **Questions Are Okay.** It is all right for children (or adults) to ask questions about wheelchairs and disabilities. Children have a natural curiosity that needs to be satisfied so they do not develop fearful or misleading attitudes. Most people are not offended by questions people ask about their disabilities or wheelchairs.
h. **Some Persons Who Use a Wheelchair for Mobility Can Walk.** Be aware of the person's capabilities. Some persons can walk with aids, such as braces, walkers, or crutches, and use wheelchairs some of the time to conserve energy and move about more quickly.
i. **Persons Who Use a Wheelchair for Mobility Are Not Sick.** Don't classify persons who use wheelchairs as sick. Although wheelchairs are often associated with hospital, they are used for a variety of non-contagious disabilities.
j. **Relationships Are Important.** Remember that persons in wheelchairs can enjoy fulfilling relationships which may develop into marriage and family. They have physical needs like everyone else.
k. **Wheelchair Use Provides Freedom.** Don't assume that using a wheelchair is in itself a tragedy. It is a means of freedom which allows the person to move about independently. Structural barriers in public places create some inconveniences; however, more and more public areas are becoming wheelchair accessible.

4. Emotional/mental health impairment

A person with an emotional or behavioral health issue may have distorted thinking. He or she may hear voices, see things that aren't there, be paranoid, or have difficulty communicating. Usually this does not mean the person is aggressive unless he or she feels threatened. Here are some communication guidelines to use:

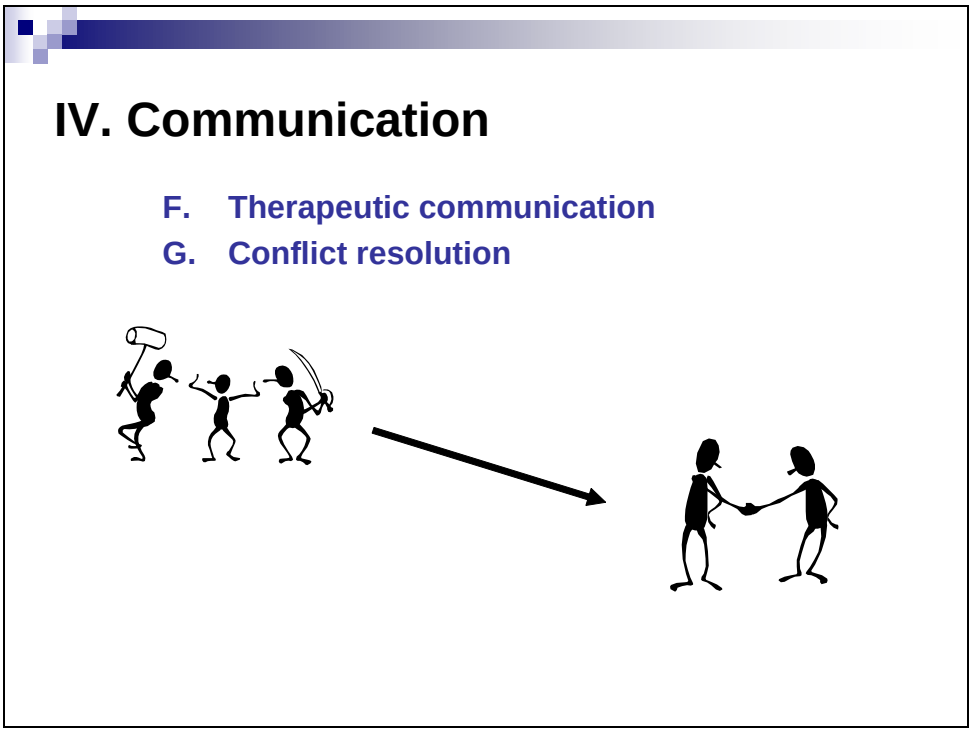
a. **If the person has difficulty having a conversation with you,** he or she may be able to enjoy your company in other ways. Consider watching television, listening to music, playing cards or being read to. Talk about childhood events.
b. Allow the person to have personal "space" in the room. **Don't stand over him or her or get too close (this includes touching the person). The individual may hit you if you try a "soothing touch" without knowing if it is safe to do so.**
c. Don't block the doorway.
d. Avoid continuous eye contact.
e. Try to remain calm with a soothing approach. Speak with a slow-paced and low-toned voice.
f. Use short, simple sentences to avoid confusion. If necessary, repeat statements and questions using the same words.
g. Establish a structured and regular daily routine. Be predictable. Be consistent. Do not say you will do something and then change your mind.
h. Offer praise continually. If the person combs his or her hair after three days of not doing so, comment on how attractive he or she looks. **Ignore the negative and praise the positive.**
i. Avoid over-stimulation. Reduce stress and tension.
j. Respect his or her feelings. Saying "Don't be silly. There's nothing to be afraid of," will get you nowhere. Allow the person to feel frightened by saying something like, "It's all right if you feel afraid. Just sit here by me for awhile."

5. Cognitive/memory impairment

A person with a cognitive/memory impairment has difficulty thinking, reasoning, and remembering. These individuals can become very embarrassed or frustrated if you ask them names, dates, what they had to eat, who called, etc. Since their long term memory is much more intact, they may dwell on events in the past and not remember such things as a relative's death or that a child has grown and married. When communicating with these individuals remember:

a. Use a calm voice and be reassuring. The person is trying to make sense of the environment.
b. Use redirection
c. Give honest compliments
d. **Do Not Argue** with the person. If the person tells you he is waiting for his wife to come and you know that his wife died several years ago, do not state, "You know your wife died several years ago." The person will either get mad because you are wrong or become grief stricken because he has just learned his wife died. It would be better to reassure the person that everything is all right; his wife has just been delayed. Then divert his attention to an activity.
e. Treat each person as an individual with talents and abilities deserving of respect and dignity. Individuals can usually tell if they are being talked down to like a child which can make the situation worse.

The two most important factors in working with the individual with a cognitive impairment are your actions and reactions to the individual and his/her behavior.



F. Therapeutic communication

a. Use open-ended comments to encourage verbalization. This prevents a person from answering yes or no.
b. Allow for the collection of more information to meet the person's needs
c. Use paraphrasing or reflective responses to clarify information. Use this method to direct the conversation to specifics.

G. Conflict Resolution

a. Use listening skills and therapeutic communication techniques listed above.
b. Listen intently to let the person know that what he has to say is very important.
c. If the person knows that what he has to say has value, he will begin to diffuse anger.
d. Do not respond with anger or become defensive.
e. Empathize. See it from his perspective.
f. Then, once he sees you are an ally, not an enemy, fill him in on your challenges, feelings, roadblocks, and/or perspective.
g. Put your own emotions on hold. Take a few minutes of "time-out" if needed to diffuse anger and gather your thoughts.

For more information about Therapeutic Communication refer to:

http://erc.msh.org/mainpage.cfm?file=4.6.0.htm&module=provider&language=English

http://www.ais.msstate.edu/AEE/Tutorial/comm_process.html

People First Language

Incorrect Terminology

Afflicted/Affliction – Implies pain and suffering. Most individuals with disabilities are not in pain, nor do they suffer because of their disability.

Confined – People with disabilities are no more "confined to a wheelchair" than people with poor vision are "confined to their eyeglasses". Both wheelchairs and eyeglasses are tools used by the individual to increase their independence. Try "uses a wheelchair for mobility", or "has a wheelchair", or "gets around in a wheelchair".

Crippled – Avoid this word unless talking about an object

Deaf and dumb or Deaf mute – People who are deaf have healthy vocal cords. If they do not speak, that is because they do not hear the correct way to pronounce words. Try "person who is deaf" or "person with a hearing impairment".

Disabled – Poor usage: "The disabled population is increasing." Preferred: "The number of people who have disabilities is increasing."

Disabled person – Try "person with a disability", thus putting the person before the disability.

Disability – A medically defined condition resulting from a brain injury, accident, virus, a combination of genetic factors, or trauma. Say "People with disabilities" not "disabled people".

Disease – Most people with disabilities are as healthy as anyone else.

Drain or burden – Try "added responsibility".

Gimp – Slang used by people with disabilities to mock society's attitudes towards them. However, it can have negative connotations if used by a person who is able-bodied.

Handicap – DO NOT use to describe a person's physical condition. Persons with disabilities are not necessarily handicapped. The term handicap refers to environmental barriers preventing or making it difficult for full participation or integration.

- Attitudes and objects in the environment that hinder one's functioning. Examples are unaccepting or condescending behaviors, steps, steep ramps, narrow doorways and curbs.
- An athletic event in which difficulties are imposed on the superior, or advantages are given to the inferior, to make their chances of winning equal. Some individuals with disabilities may call themselves "handicappers" to show that they are capable of setting their own odds and that they are in control of their own lives. However, this term is not widely accepted.
- **Handicapped parking, handicapped housing - use accessible parking or accessible housing**

Handicapped person – A better description is "person with a disability."

Invalid – This word means "not valid". EVERYBODY is valid

Patient – Use this term ONLY when referring to someone who is in the hospital or under a doctor's immediate care.

Poor – Avoid this word unless talking about a person of low financial status. A person's financial status need not be related to his/her disability.

Unfortunate – Adjective that describes someone with bad luck, not a person with a disability.

Victim – A person with a disability was not sabotaged, nor was the individual necessarily in a car, plane or train accident. Having a disability need not make a person a victim.

Suffered – Use experienced or survived to indicate having the experience and going on with life and control of life and life choices.

Used with permission and adapted from "People First Language" by Kathie Snow

PRINCIPLES OF CAREGIVING

SECTION V - GRIEF, SEPARATION, AND END OF LIFE

V. Grief, Separation, and End of Life

- A. Grief and separation process
- B. Dying process
- C. Emotional issues
  1. Consumer and family
  2. DSP

A. Grief and separation process

In the 1800's and early 1900's death was very much a part of life. Families witnessed the death of a loved one and the preparation of the burial. Then, in the middle 1900's when a family member became ill the family member went into the hospital. If the person died it was very common to "protect" the children and shelter them from the grieving process. Today, we are returning to allowing all family members to share the grieving process. Today, we have Hospice and people have the right to choose to die at home or the surroundings they choose.

Stages of Grief

Individuals do not necessarily go through all these stages in order and they may repeat stages. The grief process is unique to the individual.

1. **Shock:** Disbelief that the loss has occurred
2. **Denial:** Denial is encouraged by silence. Denial is a temporary buffer after unexpected news. The person refuses to accept the loss has occurred.
3. **Anger:** Families have a hard time with anger because the anger is displaced in all directions. Anger may be directed toward the loss, the person lost, or even a Deity.
4. **Bargaining:** "Let's make a deal". The person attempts to reconcile the loss by making deals with other people, sometimes also with a Deity.
5. **Depression:** Anger turned inward
6. **Guilt:** Usually comes from things you cannot change. **Guilt** is marked by statements of "if only I had done/been . . . "
7. **Acceptance:** Living in the present. **Acceptance and Hope** means that you understand your life will never be the same but it will go on with meaning and hope.

B. Dying process

Death comes in its own time and in its own way
Death is unique to each individual

One to three months prior to death

Withdrawal – This is the beginning of withdrawing from the outside world and focusing inward. The person's world becomes smaller, possibly involving only closest friends and immediate family. With withdrawal you will see the person possibly taking more naps, staying in bed all day, and more time sleeping becomes the norm. Verbal communication decreases and touch and wordlessness take on more meaning.

Food – We eat to live. When a body is preparing to die, it is perfectly natural that eating should stop. This is one of the hardest concepts for a family to accept. **It's okay not to eat.**

The person dying will notice a decrease in eating. Liquids are preferred to solids. Meats are the first to go, followed by vegetables and other hard to digest foods. Cravings will come and go.

One to two weeks prior to death

Disorientation – Sleeping most of the time now. A person can't seem to keep their eyes open. They can, however, be awakened from the sleep. Confusion can take place when talking to the person and the person may start talking about previous events and people who have already died. The focus is transition from this world to the next.

Physical changes:
Blood pressure often lowers; pulse beat becomes erratic, increasing or decreasing.
Skin color changes.
Breathing changes, erratic rhythm, either increasing or decreasing.

One to two days, to hours prior to death

A burst of energy may be present.
Breathing patterns become slower and irregular, sometimes stopping for 10 to 45 sec.
Congestion may be audible.
Eyes may be open or semi-open and have a glassy haze.
Hands and feet become purplish and parts of the body become blotchy.
The person becomes non-responsive.

C. Emotional issues

1. Consumer and family

Individuals are unique in their display of emotions. Just because the person does not display what others think is "normal" does not mean that they are not grieving.

Some differences in grieving:

- Some people are quite vocal; some are quiet
- Some are accepting; some are in denial or shock
- Some people weep; some are very stoic (emotionless)
- Some people are angry; some may appear happy

2. DSP

It is only natural that the DSP and the person being cared for build a rapport. When that person dies the DSP may grieve as though the person was a family member.

If this is the case the DSP may want to use the coping strategies in the next section.

Exercise:

This exercise will help you understand the dynamics of a family dealing with a loss, whether it is through death of a loved one, disability, or any other major change.

Envision a child's mobile. Imagine on the mobile are five family figures: Mom, Dad, Sister, Brother, and Grandmother. The family is in balance until a family diagnosis takes place.

Let's say the brother has just been in an accident and has sustained a spinal cord injury. Remove the brother from the imaginary mobile and what happens? The mobile becomes out of balance and for the mobile of the family to get in balance again, everyone needs to negotiate their position to get the family in balance.

This is the best scenario. Often what happens is the sister is going through her own crisis from just being a teenager. Dad might not be able to deal with the added changes and starts drinking. Grandma is in her own world. Sometimes, the whole family mobile is trying to be balanced by one person.

V. Grief, Separation, and End of Life

- D. Coping strategies
  - 1. Consumer and family
  - 2. DSP
- E. Community resources
- F. Cultural and religious issues
- G. Advance directives
- H. "Orange Form" (DO NOT RESUSCITATE)
  - 1. Agency-specific policies and procedures
  - 2. Display

D. Coping Strategies

1. Consumer and family

Part of **healthy grieving** is to allow yourself to grieve — Not doing so can cause emotional and/or physical problems later on. Take care of yourself by:

Talking — to a social support system, to clergy or a counselor
Writing — journaling, even writing letters to the deceased person about things you wished you would have said
Reminiscing — remembering the good times, plant a garden in the person's honor, support causes the person was involved in
Getting enough sleep, exercising, and eating healthy — to keep your body healthy. Do no turn to alcohol or drugs to "numb the pain"— this usually makes the situation worse.
Planning ahead — Realize that anniversaries, holidays and special days will be difficult at first. Plan to spend time with a valued social support.

Don't be reluctant to ask for help — Help is out there, just ask.

DSP's need to be aware of the needs of the people they are assisting. If you think a consumer is not grieving in a healthy way, talk to your supervisor. He/she may be able to arrange agency or community resources.

2. DSP

As previously mentioned people grieve differently so allow yourself to grieve in your own way. You may need to talk to a valued social support. You may need to have some relaxation time. Try to be good to yourself and seek out the help that you need. Your supervisor may be very helpful in arranging agency or community resources to assist you.

E. Community resources

- Area Agency on Aging— Senior Help Line (602) 264-2255
- Community Information and Referral (602) 263-8856
- Valley Interfaith Project (602) 248-0607
- If the deceased person was open to Hospice services, contact the social worker for that Hospice agency

F. Cultural and religious issues

Cultural and family differences will influence the death and dying process. DSP's need to be aware of the various beliefs and practices of the people for whom they are providing care. But as you can see below, the cultural differences are so varied that it is difficult to become culturally competent in all areas. Contact your supervisor to give you direction on how to handle the individual needs.

Some Jewish families forbid embalming and autopsy.
Some religions discourage an autopsy.
Some religions will not allow non-family to touch the body.
Some religions does not want the body to be touched 8-30 minutes after death.
Some religions cover the mirrors in the home after a family member dies.
Some religions remove water from the room after family member dies.

G. Advance directives

Advance Directives are documents specifying the type of treatment individuals want or do not want under serious medical conditions in which they may be unable to communicate their wishes. These documents provide written proof of the expressed wishes, rather than making the family guess what is desired. Making desires known in advance prevents family members from making such choices at what is likely one of the most stressful times in their lives. Further, providing such information and designating a health care power of attorney means that the physician knows whose direction is to be followed in the event the family disagrees as to what medical treatment the individual desires.

Generally two forms are involved with Advance Directives:

Living will: Legal document that outlines the medical care an individual wants or does not want if he or she becomes unable to make decisions.

Durable medical power of attorney: Legal document that designates another person to act as an "agent" or a "proxy" in making medical decisions if the individual becomes unable to do so.

Advance Directives can be completed by an individual (must be done while the person is still competent) and does not need to be done by an attorney. In Arizona the forms do not have to be notarized; but if the individual ever moves to another state that requires notarization, the forms will be invalid.

H. "Orange Form" (DO NOT RESUSCITATE)

The **Pre-Hospital Medical Care Directive, also known as the "Orange form",** is a special Advance Directive. This form says that. If the heart stops beating or breathing stops, that individual **does not want to receive cardiopulmonary resuscitation (CPR) under any circumstances.** This special form, which is bright orange in color, notifies the paramedics and emergency medical services people that this choice has been made.

1. Agency-specific policies and procedures

The policies and procedures for honoring an orange form vary from agency to agency. Some agencies have policies that mandate that the DSP would provide CPR measures (if certified) whether the individual has an orange form or not. Other agencies have a procedure to follow if the individual you are caring for has a valid orange form.

When the DSP notes that the consumer has an orange form, the DSP should contact his/her supervisor to determine the policies and procedures related to CPR for the consumer.

It is also important to **remember that the orange form only covers cardiac and respiratory arrest.** If the consumer has another type of medical emergency, the DSP should provide first aid measures including calling 911 as indicated.

2. Display

Because the paramedics respond quickly to an emergency medical situation, the Pre-Hospital Medical Care Directive (Orange form) must be immediately available for them to see. Therefore, it should be displayed someplace where the paramedics will be able to see it should the individual have a cardiac and/or respiratory arrest. Such places would be the refrigerator or behind the living room door.

Resources:

Advance Directives information for individuals residing in Arizona can be obtained from:

Health Care Decisions at: http://www.hcdecisions.org/

Arizona Attorney General's Website at:
http://www.azag.gov/seniors/life_care/FAQ.html#2

Grief Activity

Purpose of exercise is to have the class experience letting go of friends, family, and activities they dearly love. This exercise relates to some of the grieving indicators the people being served by DSP's experience.

Supplies: 15 pieces of paper approximately (1" x 2") for each student, pens, garbage can.

Activity: Have each student think of 5 family members, 5 friends or acquaintances, and 5 activities they like to do (example: reading, watching TV, tennis, bowling, sewing, running, etc.). Have the students write the name of a family member, friend, or activity on each piece of paper. Then have the students arrange the pieces of paper so they can see each one. Ask the students to take some quiet time and think of **each** person and **each** activity they have chosen. Wait approximately 2-5 minutes. You can even turn the lights low and play some soothing music.

Now the true exercise begins. Talk to the students about the following scenarios.

Scenario #1: "Imagine you were just in a car accident and you have sustained a spinal cord injury." Ask your students: "What activities have you chosen to do that now as a wheelchair user will prevent you from participating in the activity? Tear up those activities and discard them. Are there any people you directly do these activities with? Tear their names up and discard them."

Scenario #2: "Imagine you have a persistent cough, so you go to the doctor and you find out you have cancer and you will need to undergo chemo therapy. It is suggested that you will probably need to take a year leave of absence from work. Did you write down the names of any people you see at work? Tear up the names and discard them."

Scenario #3: "Imagine you have just found out you have been diagnosed with inoperable blindness. How will this affect the activities you have chosen? Tear up and discard the activities you will not be able to do because you are blind."

Scenario #4: "Now I want you to take two people you have chosen and just put them aside. How would you feel if they were not involved in your life anymore?"

Have class participate on how they felt when they needed to actually tear up and discard any activities or people? How did they feel when they needed to remove and put two loved ones aside?

PRINCIPLES OF CAREGIVING

SECTION VI - STRESS MANAGEMENT

VI. Stress Management

- A. Identification and causes of stress
  - 1. Components
  - 2. Causes/Effects
  - 3. Indicators
- B. Coping strategies

A. Identification and causes of stress

Stress is a daily component of our lives. Learning to manage stress is essential, not only to be effective in the workplace, but also to protect your health.

Stress is often viewed negatively. It occurs from too much work, unrealistic deadlines, and financial pressures. Stress is also triggered by some of life's happiest moments such as getting married, having a baby, buying a home, or starting a new job. These events are often associated with positive outcomes, yet because they are meaningful, they require a lot of personal energy and investment. In these situations, stress acts as a motivator.

When the stress level is manageable or when we have developed effective coping mechanisms, the impact of stress on our lives is minimal. Unfortunately, we do not always recognize the degree of impact. In addition to "feeling out of control" in our lives, unmanageable levels of stress may actually cause or exacerbate new or already existing problems in totally unrelated areas such as relationship difficulties, financial concerns, and work-related problems.

Stress is like getting ready to hit a baseball and wearing a blindfold to hit the ball.

1. Components

The research shows that some stress is good. Stress ‘revs up’ the body thanks to naturally-occurring performance-enhancing chemicals like adrenalin and cortisol, hormones that get us prepared for emergency action. This gives a person a rush of strength to handle an emergency (“fight or flight”). It also heightens ability to fight “tigers” in the short term.

However, if severe stress is allowed to go unchecked in the longer term, performance will ultimately decline. Not only that, the constant bombardment by stress related chemicals and stimulation will weaken a person's body. And ultimately that leads to degenerating health. In extreme cases, it can cause psychological problems such as Post Traumatic Stress Disorder or Cumulative Stress Disorder.

2. Causes/effects

WHAT HAPPENS WHEN YOU ARE STRESSED?

	Normal (relaxed)	Under pressure	Acute pressure	Chronic pressure (stress)
Brain	blood supply normal	blood supply up	thinks more clearly	headaches or migraines, tremors and nervous tics
Mood	happy	serious	increased concentration	anxiety, loss of sense of humor, cry, depression, rage, difficulty sleeping
Saliva	normal	reduced	reduced	dry mouth, lump in throat
Muscles	blood supply normal	blood supply up	improved performance	muscular tension and pain
Heart	normal rate and blood pressure	increased rate and blood pressure	improved performance	hypertension and chest pains
Lungs	normal respiration	increased respiration rate	improved performance	coughs and asthma
Stomach	normal blood supply and acid secretion	reduced blood supply and increased acid secretion	reduced blood supply reduces digestion	ulcers due to heartburn and indigestion stomach pain
Bowels	normal blood supply and bowel activity	reduced blood supply and increased bowel activity	reduced blood supply reduces digestion	abdominal pain and diarrhea
Bladder	normal	frequent urination	frequent urination due to increased nervous stimulation	frequent urination, prostatic symptoms
Sexual Organs	(male) normal. (female) normal periods etc	(m) impotence (decreased blood supply) (f) irregular periods	decreased blood supply	(m) impotence (f) menstrual disorders
Skin	healthy	decreased blood supply - dry skin	decreased blood supply	dryness and rashes
Biochemistry	normal: oxygen consumed, glucose and fats released	oxygen consumption up, glucose and fats consumption up	more energy immediately available	rapid tiredness, no energy

3. Indicators

The indicators that a person is under unmanageable stress can be found in the last column above. Signs and symptoms would include:

- crying
- depression
- no energy
- anxiety
- not sleeping
- stomach pains

B. Coping strategies

Unhealthy coping strategies include drugs, alcohol, and cigarettes. These mask the problems and only delay finding a solution and implementing an action plan.

If you find that you or the individual/family you are assisting is having any of the symptoms listed above, try to identify the reason or cause of the stress and develop an action plan to manage the stress. Following are some effective, healthy stress management coping strategies.

Reason for Stress	**Action to Take**
Unrealistic expectations	Set realistic goals
Negative thinking	Consciously choose to think positively. Think of the positives in your life
Feeling of being out of control	Act—Do not react--- Make an action plan
Someone else setting limits for you – being domineering	Understand what you are responsible for. Evaluate and then take the appropriate action. Be assertive (refer to assertive communication)
Not feeling confident of what you are doing	For job related—talk to your supervisor for direction—take advantage of in-services—ask questions (This is referred to as professional growth) —**all** employers would rather you ask questions than handling the aftermath of mistakes For personal advice-- seek out a valued friend, clergy, or counselor.
Feeling overwhelmed	ASK FOR HELP Make a plan to break up the task into smaller pieces

Necessary components of effective stress management include:

- strong social support
- exercise
- diet
- rest
- realistic expectations
- positive self-talk
- time-management
- effective communication
- relaxation techniques

Relaxation Techniques

1. Deep Control Breathing

Take a deep breath of air through the nose and slowly release the air through your mouth. Good air in, stressed air out.

Get in a comfortable position. You can do this either sitting or lying down. When lying down put your hand on your stomach, take a deep breath through your nose and then let it out through your mouth. Let your hand feel your abdomen go up and down while taking the deep breaths.

You can do this while sitting in traffic, on hold on the phone, watching TV at commercial time, etc.

2. Progressive Muscle Relaxation

a. Get in a comfortable position. If possible lay down. Let your whole body relax gradually.
b. Breathe slowly through your nose. Feel the cool air as you breathe in and out. Let your awareness turn away from your daily cares and concerns. Close your eyes and let your awareness turn inward to the physical sensations of your body.
c. Tighten the muscles of your face. Feel the tension in your face. Hold for ten seconds. Release. Feel the tension flow outward.
d. Tighten your eyebrows by squeezing them. Feel the tension by your eyebrows. Hold for ten seconds. Release and feel the tension flow outward.
e. Clench your jaw tight. Feel the tension in your jaw. Hold for ten seconds. Release. Feel your jaw drop. Allow your jaw to drop.
f. Squeeze your neck muscles and hold for ten seconds. Release. Feel the tension leave your face. You feel relaxed. You are relaxed.
g. Take a deep breath and hold. Feel the tension in your chest from holding your breath. Exhale and feel the tension leave your body. Repeat.
h. Tighten your fists or your arms. Feel the muscle tension. Hold for ten seconds. Release and feel the tension travel down your arms.
i. Open your fingers on your hands and feel the tension slip out from your fingers. You are feeling so relaxed. You are relaxed.
j. Stretch and tighten you toes. Hold. Release. Feel the tension leave your toes.

k. Squeeze your legs together and feel the tension in your legs. Hold for ten seconds. Release and feel the tension leave your body. You feel relaxed. You are Relaxed.
l. Breathe in through your nose and slowly say, “I am”, exhale through your mouth and say, “relaxed”.

3. Autogenic Imagery

You can use the autogenic exercise in several different positions. This is useful if you are at the office or in a meeting. Sit in an armchair with your head, back, and arms in a comfortable, supportive position. Sit as relaxed as possible. If you are at home lie down with your head supported, legs about eight inches apart, toes pointed slightly outward, and arms resting comfortably at the side of your body without touching it. If at home close your eyes. Let your mind be like a quiet pool, with no thoughts rippling the surface.

Simply say the following phrases to yourself: Repeat each phrase slowly three to four times.

My head is heavy and calm
My face is warm and relaxed
My eyelids are heavy and warm
My jaw is heavy and relaxed
My shoulders are heavy and warm
My right hand is heavy and warm
My left hand is heavy and warm
My chest is heavy and relaxed
My abdomen is soft and warm
My right leg is heavy and warm
My left leg is heavy and warm
My breathing is calm and regular
My heartbeat is calm and regular
My stomach is calm and relaxed
My body feels quiet and comfortable
My mind is quiet and refreshed
I am relaxed and refreshed

Be creative in using your own symbols for how your body can heal itself

4. Guided Imagery

Guided Imagery is fun to do. Go to your happy place, your own private happy place. *I am relaxed!* If you are on the beach:

It is a perfect day at the beach
The sand is warm
You can feel the gentle breeze caress your face
Feel the gentle warmth of the sun all over your body
You can even feel the warm sand run through your fingers
Can you hear the waves gently lapping onto the shore?
You can see the water as if there were diamonds sparkling.

As you look at the ocean you see the endless horizon.
This is real. This is real. This is real.
I am relaxed. I am relaxed. I am relaxed.
Focus on your special place and feel every aspect of your happy place.

Benefits of being able to manage stress:

Look forward to getting up in the morning
More energy
Positive attitude
Able to make better decisions
Feel lighter

Remember to practice your favorite relaxation technique on a regular basis--

Doing your favorite relaxation technique is like working out at a gym to build more muscle. You need to work out regularly to build muscle.

PRINCIPLES OF CAREGIVING

SECTION VII - TIME MANAGEMENT

VII. Time Management

A. Importance
B. Prioritizing duties
C. Developing work schedule

A. Importance

It is a given that when providing assistance, it is very important to work smarter. That is to prioritize tasks and try to plan ahead so that you will have time for those unforeseen emergencies.

If you spend too much of your time responding to immediate problems, you might be moving into the danger zone of high stress levels and possible burn-out. People whose lives seem always to be at the mercy of circumstances are usually those who wait for things to happen, and then react to them. People who seem more on top of things are usually those who see things coming, and act in good time to guard against them (or benefit from them).

Do not neglect activities just because they are not urgent, otherwise they soon will be (i.e. putting off getting gas until the last minute and then not being able to find a gas station). You should aim to schedule at least half your time planning ahead, leaving the rest of your time available for reactive and maintenance tasks (i.e. keeping things running smoothly), as well as unexpected interruptions, which may occur anyway. An example is deciding what you will wear the next day and laying it out the night before, cutting down the last minute rush in the morning.

Remember, one of the biggest robbers of time is procrastination. You need to develop the skill of not putting off unpleasant tasks until later because later can become URGENT!

B. Prioritizing duties

Before you can develop a work schedule you should make a list of all the tasks that need to be done. Prioritize your daily tasks list by assigning a value (A, B, or C) to each item on the list. Place an "A" next to items that must be done. Place a "B" next to any task that is important and should be done. That is, after all the "A" tasks are completed, and you have time, you would work on the "B" items. Finally, write a "C" next to any task that is less

important and could be done later. That is, after the "A" and “B” tasks have been completed, you'll do the "C" tasks.

Category A – Must be done: Activities include those that possibly affect the health and safety of the consumer. Examples would be bathing for an individual who is incontinent or washing soiled bed linens.

Category B – Important and should be done: Category B activities allow you to plan ahead but can wait until A tasks are done. Care must be taken because Category B can quickly become Category A. Examples would be grocery shopping for needed staples and shampooing hair for a family outing.

Category C – Less important and could be done: Activities in this category can be done when the A and B tasks are done. Examples would be rearranging dresser drawers or polishing silverware.

You may even want to prioritize further by giving a numerical value to each item on the list. In other words, determine which "A" task is most important and label it "A-1." Then decide which "A" item is next most important and label it "A-2," and so on. Do the same for "B" and "C" tasks.

C. Developing work schedule

Note: Discuss the need to be FLEXIBLE

Procedures for developing and implementing a work schedule:

1. Establish a time for planning the beginning of a shift or each week.
2. Enter all fixed activities in your schedule (i.e. the consumer has an assigned wash time in the community laundry of Wed. mornings).
3. Use the list that you developed above to identify and prioritize all the tasks you have to complete.
4. Complete your schedule by transferring the items on your priority tasks sheet to your schedule. Put the "A" Items first, followed by the "B" items, and finally as many of the "C" items you think you can accomplish.
5. Each evening check your schedule for the next day and make modifications as needed (i.e., changes in appointments, unexpected assignments, or unusual demands on time).
6. Try to combine activities -- Use the "Two-fer" concept and let dishes soak while you are washing clothes.
7. Make room for entertainment and relaxation for both you and the consumer. Plan fun activities in your priority list.

As you plan the schedule for the consumer make sure you plan time for yourself. Use these same tips to schedule tasks for your personal life. Make room for entertainment and relaxation. Make sure you have time to sleep and eat properly. Sleep is often an activity (or

lack of activity) that DSP's use as their time management "bank." When they need a few extra hours for activities or work, they withdraw a few hours of sleep. Doing this makes you tired, less productive, stressed out and burned out.

Note: Discuss the need to contact the supervisor if:

1. The consumer is piling too many tasks on the DSP (being unreasonable with expectations)
2. The DSP is being asked to do something that is not on the care/support plan.

Time Management Activity

Break into groups and plan a work schedule for this scenario.

You have been assigned to provide care for Kathy three mornings a week (M-W-F) from 8 to 11am. Kathy needs assistance with showering. She occasionally soils the linens at night. She needs help in preparing breakfast and lunch but can feed herself. You need to prepare breakfast and put something in the refrigerator for lunch (her relative fixes dinner for her). You need to do the shopping and pick up her meds. She has a Dr's appt at 9:30am on Wed and a relative will be picking her up at 9:15. The following cleaning tasks are listed on her care support/plan:

Daily cleaning tasks

- Pick up toys, magazines, newspapers, etc., especially if in the walkway
- Make beds
- Empty wastebaskets and take out trash
- Do dishes and wipe off counters
- Clean top of the stove
- Sweep kitchen

Weekly cleaning Tasks

- Change bed linens
- Dust furniture
- Clean shower and tub
- Clean switch plates
- Clean mirrors
- Vacuum floors and carpets
- Mop floors

PRINCIPLES OF CAREGIVING

SECTION VIII - OBSERVING, REPORTING, DOCUMENTING, and CARE/SUPPORT PLANS

VIII. Observing, Reporting, Documenting, and Care/Support Plans

- A. Purpose and importance
- B. Care/support plans
- C. Observing and monitoring
  1. Signs and symptoms of illness/injury
  2. Changes in mental/emotional status
  3. Changes in home environment
- D. Reporting
- E. Documentation guidelines

A. Purpose and importance

The purpose of observing, reporting, and documenting is to communicate any changes or status that may be occurring with the consumer and/or family. Since the consumer may even be unaware of changes, it is vitally important for the DSP to communicate with other team members (including the consumer's family as appropriate). This can be accomplished through **Observing** and monitoring for any changes, and **reporting** and **documenting** those changes.

Report/Document only things that you saw or did YOURSELF. The information that is communicated will help the supervisor act accordingly. The DSP becomes the "Eyes and Ears" for the supervisor and so the DSP's accurate input is vitally important.

B. Care/support plans

1. A care or support plan (depending on the agency terminology) is a written plan created to meet the needs of the consumer.
2. The plan is usually created during an in-home assessment of the consumer's situation, the strengths and care being provided by family and friends.
3. The plan defines the needs and objectives/goals for care.
4. The plan lists the actions to be provided by the DSP.
5. Any deviations from a care or support plan may put the DSP at risk for disciplinary action. **Therefore, any changes need to be approved by the supervisor.**
6. Care/support plans are reviewed by the care team. The DSP working on the case may be asked for input as to how the plan is working. Reporting and documenting are very critical in evaluating whether the plan is working or if it needs revision.

Refer to the examples of various care and support plans

C. Observing and monitoring

Recognizing Changes – The DSP as Detective

- Early identification of changes in an individual's daily routines, behavior, ways of communicating, appearance, general manner or mood, or physical health can save his or her life.
- You get to know a person by spending time with him or her and learning what is usual for them. If you don't know what is normal for a person, you won't know when something has changed.

Tools The DSP May Use

- Observation -- Using all of your senses: sight, hearing, touch and smell.
- Communication -- Includes asking questions and listening to answers. A good listener hears both words and other ways of communicating, including behavior.

1. Signs and symptoms of illness/injury

Signs are what can be observed; symptoms are what are experienced by the consumer)

Physical Health: Changes in physical health are often identified by changes involving a particular part of the body. Some are changes you may observe, and others are changes an individual may tell you. For example, you may observe that an individual is pulling his ear or an individual may tell you that his ear hurts.

- You may want to ask, "Is there any apparent change to the individual's skin, eyes, ears, nose, or any other part of the body?"

Physical changes to pay attention to include:

- **Skin:** Red, cut, swelling, rash.
- **Eyes:** Redness, yellow or green drainage, swelling of the eyelid, excessive tearing, or the individual reports eyes burning and/or pain.
- **Ears:** Pulling at ear, ringing in the ears, redness, fever, diminished hearing, drainage from the ear canal, the individual reports dizziness or pain.
- **Nose:** Runny discharge (clear, cloudy, colored), rubbing nose.
- **Mouth and throat:** Refusing to eat, redness, white patches at the back of the throat, hoarse voice, fever or skin rash, toothache, facial or gum swelling, gum bleeding, fever, individual reports pain when swallowing.
- **Muscles and bones:** Inability to move a leg or an arm that the individual could previously move, stiffness, limited range of motion, individual reports pain in the arms, legs, back.
- **Breathing (lungs):** Chest pain, cough, phlegm (mucous), shortness of breath or wheezing, fever, rash, stiff neck, headache, chills, nasal congestion, individual reports pain in nose or teeth, dizziness.
- **Heart and blood vessels:** Numb or cold hands or feet, swelling of ankles, chest pain, shortness of breath.
- **Abdomen, bowel, and bladder (stomach, intestines, liver, gallbladder, pancreas, urinary tract):** Constant or frequent abdominal pain; bloating; vomiting; loose stools or diarrhea; constipation; blood in vomit or stools; fever; fruity smelling breath; difficult, painful and/or burning urination; changes in urine color (clear to cloudy or light to dark yellow); fruity smelling urine; nausea; pain on one or both sides of the mid-back; chills.

- **Women's health:** Vaginal discharge, itching, unusual odor, burning, changes in menses, such as change in frequency, length, and flow.
- **Men's health:** Discharge from penis, pain, itching, redness, burning.

Warning signs of injury that require medical attention

- Joint deformity—Limb is out of alignment with the rest of the extremity
- Joint pain or tenderness—Does finger pressure to the area cause pain
- Swelling— Swelling within a joint causes pain and can even cause a clicking noise as the structural tendons and ligaments get pushed into new positions
- Decreased range of motion of the affected joint or limb
- Numbness or tingling—This may be a sign of nerve compression

For treatment of injuries, refer to section XII on Emergencies

2. Changes in mental/emotional status

Behavior: an individual who is usually calm starts hitting and kicking; appears more or less active than usual.

- You may want to ask, "Does the individual appear more or less active than usual?" "Is the individual acting aggressively to himself or to others?"

Ways of communicating: an individual who usually talks a lot stops talking; speech becomes garbled or unclear.

- You may ask, "Has the individual's ability to talk or communicate changed?"

Appearance: an individual who is usually very neat in appearance now has uncombed hair; is wearing a dirty, wrinkled shirt; changes in color or appearance (a sudden redness on the hands or an ashy tone and clammy feel to the skin); any changes in weight, up or down.

- You may ask, "Does it seem like the individual has lost interest in things?" "Is the individual taking less care in his or her dress?"

General manner or mood: Someone who is usually very talkative and friendly becomes quiet and sullen; an individual who usually spends her free time watching TV with others suddenly withdraws to her room and wants to be alone.

- You may ask, "Has the individual's mood changed?" "Does the individual want to be alone all the time?"

Family/social relationships: Is there someone interacting with the consumer who is causing emotional distress such as stealing, drug activity, being verbally or physically abusive.

3. Changes in home environment

Finances: Are there unpaid bills? Have utilities been cut off? Is there sufficient food on hand?

Cleanliness: Has there been a change in housekeeping routines? Can the individual continue doing household chores?

Home maintenance/safety: Are there repairs that need to be done that could cause a health or safety hazard?

D. Reporting

Now that you have observed changes or monitored consumer status the DSP needs to **REPORT** the changes. **Reporting** is the verbal communication of observations and actions taken to the team or supervisor. A verbal report is given to a supervisor when the need arises or for continuity of care (i.e., giving a verbal report to the next shift).

1. It is always better to report something than to risk endangering the consumer, the agency, and yourself by not reporting it.
2. Reporting helps your supervisor act accordingly.

E. Documenting

Documenting is the written communication of observations and actions taken in the care of the consumer.

1. Two important phrases**--"If it wasn't documented, it wasn't done**" and **"The job is not over until the paperwork is finished"**

2. Documentation is significant because it is:

    a. A record of what was done, observed, and how the consumer reacted
    b. Used for evaluation by other team members of the care plan.
    c. Used to clarify complaint issues.
    d. **Always remember that the consumer record is a legal document.**

3. Documentation Guidelines:

    a. Always use ink.
    b. Sign all entries with your name and title, if any, and the date and time.
    c. Make sure writing is legible and neat.
    d. Use correct spelling, grammar, and punctuation and abbreviations (Refer to the Standardized Medical Abbreviations list on the following pages).
    e. Never erase or use correction fluid. If you make an error, cross out the incorrect part with one line, write "error" over it, initial it, and rewrite that part.
    f. Do not skip lines. Draw a line through the blank space of a partially completed line or to the end of a page. This prevents others from recording in a space with your signature.
    g. Be accurate, concise, and factual. Do not record judgments or interpretations.
    h. Make entries in a logical and sequential manner.
    i. Be descriptive. Avoid terms that have more than one meaning.
    j. Document any changes from normal or changes in the consumer's condition. Also document that you informed the consumer's physician or your supervisor as indicated.
    k. Do not omit any information.
    l. Try to relate your charting to the objectives/goals on the consumer's plan, i.e. if it is walking, "walked 3 times today without assistance from bedroom to kitchen" instead of "had a good day today".

Documentation Activity

Using the documentation guidelines, what would your documentation look like in this situation?

> Example: Sara (consumer) has not been eating much lately so the goal is to increase her intake. During your shift today, she ate all of her lunch.

The documentation may look something like this:

XYX Agency

Progress Notes

Client Name: Sara Jones

Date/Time	Action/Observation
9/29/05 3:15pm	Sara ate all of her chicken salad sandwich and 1/2 cup jello w/ bananas for lunch. Sara stated she liked the bananas and enjoyed using her good china and having flowers on the table. — Susie Worker

What would your documentation look like in these situations?
What would you report?

1. When you arrived at Sara's house today she stated that she had fallen during the night. She is not complaining of pain except for a bruise on her leg.

2. While you were washing dishes you broke a plate.

3. During your shift Sara had an episode of chest pain. She took a nitroglycerin tablet and the pain went away.

XYX Agency

Progress Notes

Consumer Name:

Date/Time	Action/Observation

Optional: Medical Abbreviations and the following activity depending on the needs in your agency

Standardized Medical Abbreviations and Acronyms

abd	abdomen	dc, d/c	discontinued
ac	before meals	dias	diastolic
AD	right ear	DM	diabetes mellitus
ADL	activities of daily living	DOA	dead on arrival
ad lib	as desired	Dx	diagnosis
AM	between 12 midnight & noon	ECF	extended care facility
		ECG, EKG	electrocardiogram
AP	apical pulse	EEG	electroencephalogram
AROM	active range of motion	EENT	eyes, ears, nose, & throat
AS	left ear	EMG	electromyogram
ASA	aspirin	ENT	ears, nose, throat
ASAP	as soon as possible	ER	emergency
ASHD	arteriosclerotic heart disease	FBS	fasting blood sugar
		Fe	iron
as tol	as tolerated	Fib	fibrillation
AU	both ears	ft	feet
ax	axillary	Fx	fracture
bid	two times a day	FWB	full weight bearing
BM	bowel movement	GI	gastrointestinal
BP	blood pressure	Gm	gram
BRP	bathroom privileges	gr	grain
BS	bowel sounds	gtts	drops
c	with	GU	genitourinary
CAD	coronary artery disease	Gyn	gynecology
cal	calorie	H2O	water
cap	capsule	H2O2	hydrogen peroxide
CBC	complete blood count	hgb	hemoglobin
cc	cubic centimeter	hr	hour
C & DB	cough & deep breathe	hs	hour of sleep
CHF	congestive heart failure	ht	height
chol	cholesterol	Hx	history
CNS	central nervous system	ICU	intensive care unit
COPD	chronic obstructive-pulmonary disease	IM	intramuscular
		I & O	intake and output
CPR	cardiopulmonary resuscitation	IPPB	intermittent positive pressure breathing device
CVA	cerebrovascular accident		

I/S	instruct & supervise
K	potassium
lab	laboratory
lb, #	pound
liq	liquid
MD	medical doctor
med	medication
mEq	milliequivalents
mg	milligram
MI	myocardial infarction
min	minute
ml	milliliter
mm	millimeter
MOM	milk of magnesia
MS	multiple sclerosis
MSW	medical or master Of social work
Na	sodium
Neg	negative
Neuro	neurology
No, #	number
NPO	nothing by mouth
NS	normal saline
nsg.	Nursing
N & V	nausea and vomiting
NWB	no weight bearing
O2	oxygen
OD	right eye
OR	operating room
ortho	orthopedics
os	oral
OS	left eye
OT	occupational therapy
OU	both eyes
oz	ounce
pc	after meals
peri	perineal
PM	after 12 noon
po	by mouth
pre op	preoperative
prn	as necessary
PROM	passive range of motion
pt	patient
PT	physical therapy
PVD	peripheral vascular disease
q	every
qd	every day
qh	every hour
qid	four times a day
qod	every other day
qt	quart
quad	quadraplegic
RBC	red blood count
reg	regular
ROM	range of motion
Rx	prescription
s	without
SO	significant other
ST	speech therapy
Stat	at once/immediately
SQ,subq	subcutaneous
syst	systolic
Sx	symptoms
TB	tuberculosis
Tbsp	tablespoon
temp	temperature
TIA	transient ischemic attack
tid	three times a day
tol	tolerated
TPR	temperature, pulse, respirations
tsp	teaspoon
Tx	treatment
UA	urinalysis

URI	**upper Respiratory Infection**	**W/C**	**wheelchair**
UTI	**urinary Tract Infection**	**wk**	**week**
via	**by way of**	**WNL**	**within normal limits**
VS	**vital signs**	**wt**	**weight**
WBC	**white blood count**	**yr**	**year**
	**one**		
	**two**		

Medical Abbreviations
Mix and Match

1.	a.c.	_____	twice a day
2.	A.M.	_____	before meals
3.	b.i.d.	_____	four times a day
4.	cc	_____	immediately
5.	DC	_____	right eye
6.	gtts	_____	morning
7.	h.s.	_____	cubic centimeter
8.	NPO	_____	every 2 hours
9.	OD	_____	teaspoon
10.	OS	_____	three times a day
11.	OU	_____	every other day
12.	p.c.	_____	as needed
13.	P.M.	_____	drops
14.	PO	_____	discontinue
15.	p.r.n.	_____	every day
16.	q.d.	_____	after meals
17.	q2H	_____	both eyes
18.	q4H	_____	by mouth
19.	q.i.d.	_____	hour of sleep
20.	q.o.d.	_____	left eye
21.	stat	_____	nothing by mouth
22.	t.i.d.	_____	every 4 hours
23.	tsp	_____	afternoon
24.	ml	_____	milligram
25.	mg	_____	grain
26.	gr	_____	milliliter
27.	$\overline{\grave{\vert}}$	_____	two
28.	$\overline{\grave{\vert}\ \grave{\vert}}$	_____	one

PRINCIPLES OF CAREGIVING

SECTION IX - INFECTION CONTROL

IX. Infection Control

- A. Bloodborne pathogen standard
- B. Infectious diseases
  1. Hepatitis B and C
  2. Human immunodeficiency virus (HIV)
  3. Other
- C. Common non-bloodborne pathogens
  1. Tuberculosis (TB)
  2. Lice
  3. Scabies

A. Bloodborne pathogen standard

On December 6, 1991 the Occupational Health and Safety Administration, (OSHA), issued its final standard on occupational exposure to bloodborne pathogens (29 CFR 1910.1030).

Bloodborne Pathogens are pathogenic microorganisms present in human blood or OPIM (Other Potentially Infectious Material) and can infect and cause disease in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). Note: According to the Centers for Disease Control, HCV is the most common chronic bloodborne infection in the United States.

While OSHA is concerned with transmission of all bloodborne pathogens, the ruling is directed toward preventing or minimizing an employee's exposure to HBV and HIV.

OSHA regulations mandate the implementation of Universal Precautions and cover these issues in the Standard:

1. Exposure Control Plan
2. Training of Employees
3. Maintain Records of Training
4. Labeling
5. Implement And Monitor Compliance (i.e. Universal Precautions)
6. HBV Vaccination
7. Post Exposure Follow-up
8. Personal Protective Equipment (PPE)

B. Infectious diseases

1. Hepatitis B and C

WHAT IS HEPATITIS B

Hepatitis B virus (HBV) is a potentially life-threatening bloodborne pathogen. Centers for Disease Control estimates there are approximately 280,000 HBV infections each year in the U.S. Approximately 8,700 health care workers each year contract hepatitis B, and about 200 will die as a result. In addition, some who contract HBV will become carriers, passing the disease on to others. Carriers also face a significantly higher risk for other liver ailments which can be fatal, including cirrhosis of the liver and primary liver cancer. HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues. Anyone with occupational exposure to blood is at risk of contracting the infection.

Employers must provide engineering controls; workers must use work practices and protective clothing and equipment to prevent exposure to potentially infectious materials. However, the best defense against hepatitis B is vaccination.

WHO NEEDS VACCINATION?
The new OSHA standard covering bloodborne pathogens requires employers to offer the three-injection vaccination series free to all employees who are exposed to blood or other potentially infectious materials as part of their job duties. This includes health care workers, emergency responders, morticians, first-aid personnel, law enforcement officers, correctional facilities staff, launderers, as well as others.

The vaccination must be offered within 10 days of initial assignment to a job where exposure to blood or other potentially infectious materials can be "reasonably anticipated." The requirements for vaccinations of those already on the job take effect July 6, 1992.

WHAT DOES VACCINATION INVOLVE?
The hepatitis B vaccination is a noninfectious, yeast-based vaccine given in three injections in the arm. There is no risk of contamination from other bloodborne pathogens nor is there any chance of developing HBV from the vaccine. The second injection should be given one month after the first, and the third injection six months after the initial dose. More than 90 percent of those vaccinated will develop immunity to the hepatitis B virus. To ensure immunity, it is important for individuals to receive all three injections. At this point it is unclear how long the immunity lasts, so booster shots may be required at some point in the future.

The vaccine causes no harm to those who are already immune or to those who may be HBV carriers. Employees may opt to have their blood tested for antibodies to determine need for the vaccine.

WHAT IF I DECLINE VACCINATION?
Workers who decide to decline vaccination must complete a declination form. Employers must keep these forms on file so that they know the vaccination status of everyone who is exposed to blood. At any time after a worker initially declines to receive the vaccine, he or she may opt to take it.

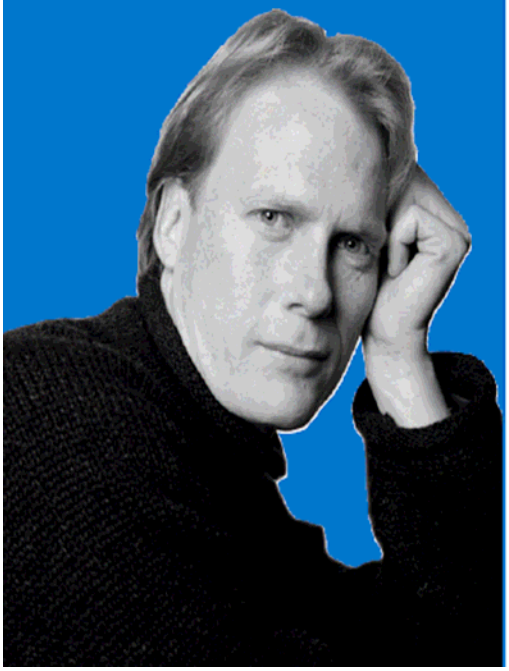
This is one of a series of fact sheets that discusses various requirements of the Occupational Safety and Health Administration' s standard covering exposure to bloodborne pathogens. Single copies of fact sheets are available from OSHA Publications, Room N-3101, 200 Constitution Avenue~ N. W., Washington DC 20210 and from OSHA offices.

WHAT IS HEPATITIS C?

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV), which is found in the blood of persons who have this disease. The infection is spread by contact with the blood of an infected person.

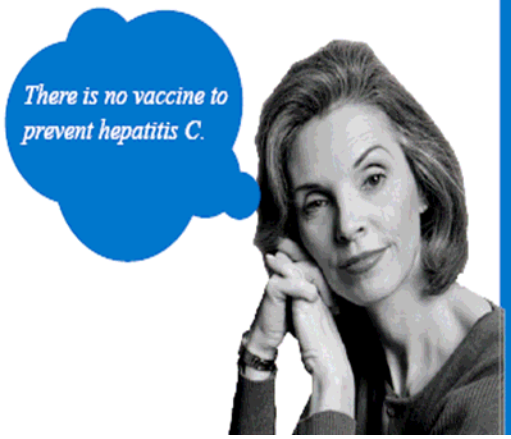
HOW SERIOUS IS HEPATITIS C?

Hepatitis C is serious for some persons, but not for others. Most persons who get hepatitis C carry the virus for the rest of their lives. Most of these persons have some liver damage, but many do not feel sick from the disease. Some persons with liver damage due to hepatitis C may develop cirrhosis (scarring) of the liver and liver failure, which may take many years to develop.



HOW CAN I PROTECT MYSELF FROM GETTING HEPATITIS C AND OTHER DISEASES SPREAD BY CONTACT WITH HUMAN BLOOD?

- Don't ever shoot drugs. If you shoot drugs, stop and get into a treatment program. If you cannot stop, never reuse or share drugs, syringes, cookers, cotton, water, or rinse cups. Get vaccinated against hepatitis A and hepatitis B.
- Do not share toothbrushes, razors, or other personal care articles. They might have blood on them.
- If you are a health care worker, always follow routine barrier precautions and safely handle needles and other sharps. Get vaccinated against hepatitis B.
- Consider the health risks if you are thinking about getting a tattoo or body piercing. You can get infected if:
  - the tools that are used have someone else's blood on them.
  - the artist or piercer doesn't follow good health practices, such as washing hands and using disposable gloves.



HCV CAN BE SPREAD BY SEX, BUT THIS DOES NOT OCCUR VERY OFTEN. IF YOU ARE HAVING SEX, BUT NOT WITH ONE STEADY PARTNER:

- You and your partners can get other diseases spread by having sex (e.g., AIDS, hepatitis B, gonorrhea or chlamydia).
- Use latex condoms. The efficacy of latex condoms in preventing infection with HCV is unknown, but their proper use may reduce transmission.
- Get vaccinated against hepatitis B.
- The surest way to prevent the spread of any disease by sex is not to have sex at all.

HEPATITIS C VIRUS IS NOT SPREAD BY:

- breast feeding
- hugging
- kissing
- food or water
- casual contact
- sneezing
- coughing
- sharing eating utensils or drinking glasses

Many people who are at risk for hepatitis C are at risk for hepatitis A and hepatitis B. Check with your doctor to see if you should get hepatitis A and hepatitis B vaccines.

FOR INFORMATION ON VIRAL HEPATITIS:

access our website at:
http://www.cdc.gov/hepatitis

or write
Centers for Disease Control and Prevention
Division of Viral Hepatitis, Mailstop G37
Atlanta, GA 30333

or
contact your state or local health department

2. Human immunodeficiency virus (HIV)

What You Need to Know About HIV and AIDS

Esta página en español

If you are going to be caring for someone with HIV infection, you need to understand the basic facts about HIV and AIDS. AIDS (acquired immunodeficiency syndrome) is caused by HIV (human immunodeficiency virus). People who are infected with HIV can look and feel healthy and may not know for years that they are infected. However, they can infect other people no matter how healthy they seem. HIV slowly wipes out parts of the body's **immune system**; then the HIV-infected person gets sick because the body can't fight off diseases. Some of these diseases can kill them.

Signs of HIV infection are like those of many other common illnesses, such as swollen glands, tiring easily, losing weight, fever, or diarrhea. Different people have different symptoms.

HIV is in people's blood, **semen**, **vaginal fluid**, and breast milk. The only way to tell if someone is infected with HIV is with a blood test.

There is no **vaccine** to prevent HIV infection and no cure for AIDS. There are treatments that can keep infected people healthy longer and prevent diseases that people with AIDS often get. Research is ongoing.

HIV slowly makes an infected person sicker and sicker. Diseases and infections will cause serious illness, but people often get better -- until the next illness. Sometimes, HIV can damage the brain and cause changes in feelings and moods, even make it hard to think clearly. Someone with AIDS can feel fine in the morning and be very sick in the afternoon. It can seem like riding a roller coaster, slowly climbing up to feeling good, then plunging down into another illness.

How HIV is Spread

The most common ways HIV is spread are:

- By having unprotected **anal**, **vaginal**, or **oral sex** with one who is infected with HIV
- By sharing needles or syringes ("works") with someone who is infected with HIV
- From mothers to their babies before the baby is born, during birth, or through breast-feeding. Taking the drug **AZT** during pregnancy can reduce the changes of infecting the baby by two-thirds, but will not prevent all babies from becoming infected with HIV.

The HIV to AIDS disease process begins at the time of infection and continues through various stages:

- Asymptomatic infection is when an HIV infected individual looks and feels healthy but is able to infect others.
- HIV Related Symptoms (sometimes called AIDS Related Complex or ARC) when the immune system has been damaged to a point where the HIV infected individual develops vague symptoms such as weight loss and night sweats which persist
- Acquired Immune Deficiency Syndrome (AIDS) with severe infections, possibly leading to death.

It is not known whether all HIV-infected individuals will progress to an AIDS diagnosis. Some people with HIV have remained well for ten years or longer. Preventive treatments also can help people with HIV remain without symptoms for longer periods of time.

Symptoms of Hepatitis B, Hepatitis C and HIV

Hepatitis B (30% have no Signs & Symptoms)	**Hepatitis C (80% have no Signs & Symptoms)**	**HIV**
Flu like	Flu like	Flu
Joint pain	Joint pain	Weight loss
Fever	Fever	Fever
Rash	Rash	Rash
Dark urine	Dark urine	Diarrhea
Yellow skin & sclera	Yellow skin & sclera	Night sweats
Abdominal discomfort	Abdominal discomfort	Swollen lymph nodes

The Body Fluids That Might Contain Bloodborne Pathogens

Blood	Breast Milk	Saliva
Urine	Tears	Cerebrospinal Fluid
Feces	Sweat	Vaginal Discharge

3. Other

There are other diseases that are caused by bloodborne pathogens such as malaria, syphilis, and eboli but all these are much less common than Hepatitis Band C and HIV.

C. Common non-bloodborne pathogens

1. Tuberculosis (TB)

Tuberculosis is still a problem. Eight million new cases occur each year in the world. In the U.S. the 30-year decline in TB cases has ended. Since 1985, the number of U.S. cases reported each year has remained above 22,000. This represents almost 15,000 more cases reported than expected. An estimated 10-15 million persons in the U.S. are infected with TB bacteria (millions of people have TB infection and have no symptoms of the disease). That is why TB screening is needed, especially for those who work in a health care setting.

Anyone can contract TB, but those at high risk include close contacts with:

- People living in substandard housing and the homeless
- Immigrants from areas of high TB prevalence
- Residents of supervised living facilities and group homes (especially nursing homes)
- Prisoners
- People who have immunosuppression diseases, such as HIV/AIDS or those who have had a recent organ transplant
- IV drug abusers
- **Health care workers**

TB is transmitted via the airborne route and inhaled. Transmission on surfaces or inanimate objects has not been documented in the literature. Repeated, prolonged exposure is considered necessary to contract TB.

The Disease Process

- Droplets with the TB bacteria are inhaled into the lungs. The bacteria multiply and may travel to other parts of the body, but this is rare. At this point, the person has a **TB infection**.
- The body's immune system begins to combat the infection. Some people may become very ill, but most people do not.
- The bacteria are encapsulated. The infection enters the latent stage. The person feels fine and is most likely unaware of the infection. They cannot spread the disease to others and treatment at this point can prevent the infection from causing the disease.
- **Note: PPD or TB Tine test will show positive at this point.**
- The bacteria become active, break out of the capsules and start to multiply. This may happen in a year or many years later. It usually happens when resistance is lowered from combating other infections and diseases such as HIV, diabetes, kidney disease, pneumonia, cancer, etc. **When the TB bacteria break out of their capsules, the person has TB disease.**
- Symptoms of the disease include:
    - Cough
    - Fatigue
    - Weakness
    - Fever
    - Weight Loss
    - Night Sweats
    - Blood in Sputum

A positive skin test indicates you have been exposed to TB Bacteria. THIS DOES NOT MEAN YOU HAVE AN ACTIVE CASE OF TB. You will need to seek medical advice to see if you have active TB. A chest x-ray and possibly a sputum analysis are

done to determine if TB disease is present and what kind of treatment is indicated. A referral is made to Maricopa County Health Department if you have active TB since TB is a reportable disease. **Once you have a positive skin test, you will need a chest x-ray to screen for the presence of TB.**

2. Lice

Lice are tiny insects that live on humans and survive by feeding on blood. When a large number of lice live and reproduce on a person, it is called an infestation. Three different kinds of lice infest humans: Head lice, Pubic lice ("crabs") and body lice. **Infestations are easily spread from one person to another through close bodily contact or through shared clothing or personal items (such as hats or hair brushes). They cannot jump or fly.**

What are the symptoms?
The most common symptom of lice infestation (pediculosis) is itching in the affected areas. Symptoms vary depending on which type of lice is present. **Head lice** may not cause any symptoms early in the infestation. Itching on the scalp may develop weeks or even months after lice have infested the person. Scratching infested areas can make the skin raw. The raw skin may weep clear fluid or crust over, and it may become infected. **Pubic lice** can cause severe itching of affected areas. Their bites may cause small bruise-like marks on the torso, thighs, or upper arms. Pubic lice most often affect the genitals, but they may also appear in the areas around the anus and armpits, in body and facial hair, and on the eyelashes. If pubic lice infest the eyelashes, the edges of the eyelids may be crusted, and lice and their eggs (nits) may be seen at the base of the eyelashes. **Body lice** can cause intense itching, especially at night. Itchy sores appear in the armpits and on the waist, trunk, and other areas where seams of clothes press against the skin. The lice and eggs (nits) may be found in the seams of the person's clothing but are generally not seen on the skin.

How is lice infestation diagnosed?
A close visual examination for live lice or nits in the hair is usually all that is needed to diagnose an infestation of head lice. A health professional may confirm the diagnosis with microscopic examination. Pubic lice and body lice can also be diagnosed with a close visual examination of the affected areas or the person's clothing. Use a fine tooth dark colored comb and comb the person's hair. Nits are like very small grains of rice.

How is it treated?
Lice and their eggs (nits) must be destroyed to get rid of an infestation. The most common treatment is a topical nonprescription or prescription cream, lotion, or shampoo to kill the lice and eggs. Sometimes a second treatment is needed to make sure that all the eggs are destroyed. When two or more topical treatments have failed to get rid of the lice, a prescription pill called ivermectin can be taken.

Call your supervisor to get directions on how to proceed if you suspect there is an infestation.

3. Scabies

Scabies are tiny, eight-legged mites that are hard to see without a magnifying glass. They dig underneath the skin and cause itching so severe it may make it difficult for the person to sleep at night. An early scabies rash will show up as little red bumps, (looks like hives), tiny bites, or pimples. Later the bumps may become crusty or scaly. Scabies usually starts between fingers, on elbows or wrists, buttocks, or waist. A woman may get them around her nipples, and a man around his penis. The mites hide around the skin near rings, bracelets, watchbands, and also under fingernails. Sometimes the person will have long red marks from where the mite has been crawling under the skin and the person has been scratching.

People in group settings such as nursing homes or group homes are more likely to get scabies.

How to know if you have scabies:
Usually a dermatologist will be able to tell if a person has scabies just from looking at the skin. If not, he/she can do a simple diagnostic test.

Treatment for scabies:

- Scabies is easy to treat with special creams and lotions. If the scabies come back after the treatment, the person should seek additional treatment from a dermatologist.
- Wash all of the person's clothes, sheets, and towels in hot water. Dry the clothing and linens completely in the dryer.
- Vacuum the whole house and throw out the vacuum cleaner bag.
- ***Treat all family members for scabies at the same time, whether they itch or not. That will keep scabies from spreading***

IX. Infection Control

- D. Transmission of disease
  - 1. Preventing spread
  - 2. Body defenses
  - 3. Risk factors
- E. Standard precautions

D. Transmission of disease

1. Preventing spread

Preventing the spread of disease depends on how the disease is transmitted and the source of the infection.

Sources of infection:

Air	Food	Water
Eating and drinking utensils	Personal hygiene equipment	Direct contact
Dressings	Insects	Animals

Common Illnesses and Modes of Transmission		
Airborne **Colds** **Flu** **Measles** **Chickenpox** **Smallpox**	**Animal** **Rabies—bite from an infected animal (dog, bat, squirrel)** **Trichinosis—eating poorly cooked pork**	**Insect** **Bubonic or Black Plague—from rat or flea bites** **Malaria—from Anopheles mosquito bite** **Dysentery- common fly may transmit organism**
Contact **Mononucleosis** **Venereal disease (syphilis/ gonorrhea)** **Hepatitis** **Tuberculosis** **Poliomyelitis**	**Human** **Typhoid Fever** **Mumps** **Impetigo** **Whooping Cough**	**Food** **Dysentery** **Botulism** **Worms** **Salmonella**
Water **Typhoid Fever** **Dysentery** **Poliomyelitis**	**Soil** **Tetanus** **Dysentery** **Worms**	

You can reduce the spread of infectious microorganisms by:

a. Washing your hands after urinating, having a bowel movement, or changing tampons, or sanitary napkins or pads.
b. Washing your hands after contact with any body fluid or substance, whether it is your own or another person's. Body fluids and substances include blood, saliva, vomit, urine, feces, vaginal discharge, mucous, semen, wound drainage, pus, respiratory secretions, and other secretions and excretions.
c. Washing your hands before handling, preparing, or eating food.
d. Washing fruits and raw vegetables before eating or serving them.
e. Providing individual toothbrushes, drinking glasses, towels, washcloths, and other personal care items for each person.
f. Covering the nose and mouth when coughing, sneezing or blowing the nose.
g. Bathing, washing hair, and brushing teeth regularly.
h. Washing cooking and eating utensils with soap and water after use.
i. Following sanitation practices such as garbage disposal and sewage treatment.
j. Germs multiply rapidly in warm, dark, moist environments so keep those areas on a person's body (i.e., groin folds) and in living areas (i.e., shower corners) clean.

2. Body defenses

Healthy individuals with healthy immune systems will stay healthy because their immune system will fight the germs. If a person's immune system is not functioning properly (decreased resistance) the person will likely get sick. Immune systems will also build up antibodies to fight bacteria so that if exposed again, the body will be able to fight the infection. **This is the reason people get immunized against certain microorganisms such as polio and tetanus.**

3. Risk factors

People are at greater risk for getting infections:

- If they have weakened immune systems such as very young or elderly persons. Young children have not yet developed a strong immune system. The immune system is more inefficient as a person ages. That is why children (age 6 months to 2 years) and elderly persons should get flu shots annually.
- If they are on medication that suppresses their immune system (organ transplants).
- If they are on prednisone.
- If they have HIV/AIDS.
- If they are not eating healthy foods, not sleeping enough, and under increased stress.

Refer to "Preventing the Spread of Disease: *Tips for Providers"* in Resources

E. Standard precautions
– Sometimes referred to as Universal Precautions

Standard precautions are infection control procedures designed to prevent health care workers from transferring infections to patients and to prevent health care workers from infecting themselves. They were developed by the Centers for Disease Control to prevent the spread of AIDS. The AIDS virus and others, such as Hepatitis B are spread through

contact with an infected person's blood. It is not possible to test everyone for all possible infections, nor is it timely. Disease causing agents may be present in body substances, even when the individual does not look or act sick. **Therefore, standard precautions should be used when coming into contact with body fluids.**

1. The purpose of Standard Precautions is to prevent or minimize exposure to bloodborne pathogens. **To be safe, standard precautions apply to any fluid emitted from the body.**
2. Approach **All** consumers as if they are HIV or HBV infectious.
3. Standard Precautions apply to tissues, blood, and other body fluids containing visible bloods.
4. Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the workplace.
5. Standard Precautions also applies to tissues, semen, vaginal secretions, and these other body fluids: cerebrospinal, synovial, pericardial, and amniotic.
6. Anticipate the kind of consumer contact and use the appropriate personal protective equipment (PPE).
7. Know the limitations of the PPE you are using, when the equipment can protect you and when it cannot.
8. Do not recap needles.
9. Do not break or otherwise manipulate needles.
10. Place contaminated sharps in puncture-resistant containers.
11. Wash hands immediately after contamination or removing gloves.
12. Standard Precautions do not eliminate the need for other category-specific or disease-specific isolation precautions, such as enteric precautions for infectious diarrhea.

IX. Infection Control

- F. Policies and procedures
  1. Hand washing
  2. Gloves and other personal protective equipment (PPE)
  3. Handling and disposal of infectious wastes
  4. Linens
  5. Cleaning the environment

F. Policies and procedures

1. Hand washing

Hand washing is one of the easiest and most effective ways to prevent the spread of infection.

Wash your hands:

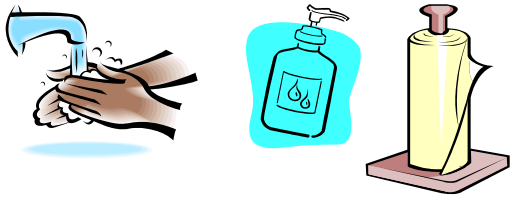
a. Immediately if contaminated with blood or other body fluids
b. Before and after contact with a consumer
c. Before and after gloving
d. After handling soiled linen or waste
e. Before and after touching wounds or waste

The removal of infectious organisms is the most important function of hand washing. Soap breaks the surface tension, but friction caused by vigorous rubbing mechanically loosens bacteria and dirt. Water washes it away. Chemicals such as alcohol or bleach should not be used to wash the hands as they may damage the skin. Frequent hand washing may cause dry and chapped skin. Lotion should be used to replace the skin's natural oils lost in hand washing and to prevent chapping. **Use of a scrub brush is <u>not</u> recommended** because it may scrape the skin. The brush is also a source of contamination. Also, avoid bar soap as it provides a good medium for bacterial growth. Proper hand washing requires that a vigorous rubbing and circular motion be used on hands (palms, sides and backs), fingers, knuckles, and between each finger for at least 20 seconds.

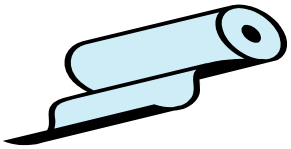
Remember: Intact skin is your best defense against bacteria.
Treat your hands well!!!!

Are you washing your hands correctly?

1. Collect the items needed for hand washing.



2. Use a clean paper towel to turn on water and adjust temperature. Wet hands with fingertips pointed down.



3. Apply soap – liquid soap in a pump is best

4. With fingertips pointing down, lather well. Rub your hands together in a circular motion to generate friction. Wash carefully between your fingers, palms, and back of hands, and rub fingernails against the palm of the other hand to force soap under the nails. Keep washing for 20 seconds (Sing "Happy Birthday" 2 times).

5. With fingertips pointed down rinse off all the soap.

6. With clean paper towel or clean hand towel dry hands. Use a clean paper towel and turn off the faucet.

2. Gloves and other personal protective equipment (PPE)

Gloves are the most important barrier method to prevent the spread of infection. Barrier methods block the transmission of any infectious agent to potential host, prevent the spread of infection, and ensure the protection of you and the person you are caring for.

Gloves: Use care when putting gloves on as rings and fingernails may cause them to tear. Heavy or prolonged use may also cause them to tear. Torn gloves are ineffective protection and should be replaced as soon as safely possible. You may also wear gloves on top of each other so that when one get very soiled you can remove it and still have another one underneath ("double gloving"). Gloves should be worn:

a. When touching blood, body fluids, body substances or mucous membranes
b. When there are cuts, breaks, or other openings on the skin
c. When there is possible contact with feces, urine, vomit, dressings, wound drainage, soiled linen or soiled clothing. This includes when handling soiled diapers, incontinence pads, linens or clothing
d. When handling oral care items, if contact with oral lesions or blood is likely
e. When cleaning, especially in the bathroom

Gloves are **not required** when bathing a consumer without skin lesions, when assisting a consumer with ambulation and transfers, when feeding a consumer or when talking with or counseling a consumer.

3. Handling and disposal of infectious wastes

Home Medical Sharps Disposal:

The handling and disposal of used home-generated medical sharps such as needles, syringes, and lancets, are exempted from regulation in Arizona's Medical Waste Regulations. However, these materials still need to be handled safely. Arizona Department of Environmental Quality needs help in ensuring that medical sharps are disposed of in a manner that helps minimize health risks to garbage haulers, landfill personnel and the community.

Medical sharps should be placed in either a purchased medical sharps container (from a pharmacy or health care provider) or a heavy-plastic or metal container. Do not use a clear or glass container. The containers should be puncture-proof with a tight-fitting lid. Household containers such as plastic detergent bottles can be used if the following precautions are observed:

- Use heavy-duty tape such as electrical or duct tape to secure the lid to the container.
- Write the words "Not Recyclable" on the container with a black indelible marker. This helps to ensure the container will not be inadvertently mingled with recyclable materials.
- Do not over-stuff the containers with medical sharps (fill to approximately 3/4 full). This can increase pressure on the lid and cause a release of the medical sharps.

While waiting for a full container, keep out of reach of children and pets. Always wash your hands after handling or touching medical sharps. Once you have followed these precautions, the container may be placed in your regular trash for disposal.

Information used with permission from:
http://www.azdeq.gov/environ/waste/solid/ic.html#sharps
Arizona Department of Environmental Quality

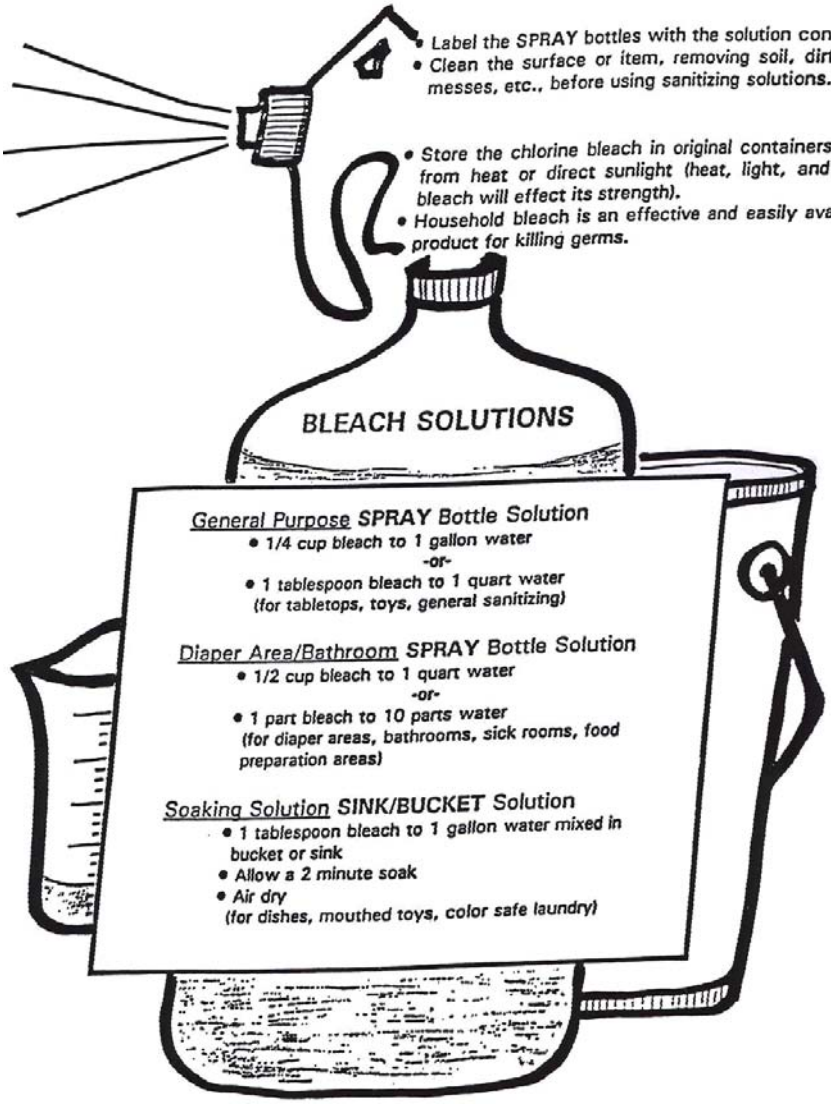
Handling of wastes other than sharps:

- Body wastes such as urine need to be flushed down the toilet
- Soiled incontinent pads or disposable gloves need to be placed in plastic bags, tied, and taken out to trash immediately so that it does not create odors in the home or grow bacteria.
- Mop water needs to be flushed down the toilet or thrown outside—**Never put it down the kitchen sink**

4. Linens

If feces or vomit is present in laundry, put on gloves. Put linens/clothes in plastic bag--don't put on floor- and take to the toilet. Rinse off the "chunky stuff" in the toilet and put back into the plastic bag. Wash linens and clothes immediately. Launder separately from the rest of the household laundry.) Add Clorox if clothes can be bleached. Otherwise, just dry completely in the dryer (the heat of the dryer will kill the bacteria). Hanging clothes out on a clothesline will also kill the bacteria.

5. Cleaning the environment



Disinfect How Often	Items to be Disinfected
Daily	Bathroom doorknobs, Sinks, faucets, and floor Toilets and flush handles Shower/tub and faucets (Bathroom Solution)
Weekly	Doorknobs, light switches, other washable floors (General Purpose)
Before Use	Food preparation areas & tables (General Purpose)
After Use	Food preparation areas (General Purpose) tableware, & food preparation equipment (Soaking Solution)
Immediately	Any surface that has been soiled with urine, stool, mucous, vomit, blood, or nasal discharge (Bathroom Solution)

Universal cleaning and disinfecting solution -- bleach 1:10

1 part bleach to 10 parts water (1:10) means that whatever measuring device you use (1/3 cup, 1 cup, a tablespoon), you mix 1 measure of bleach and 10 measures of water. For example you could pour 1/4 cup of bleach and (ten) 1/4 cups of water into a spray bottle and label the bottle.

Contact time (the amount of time needed for the bleach to work) is the amount of time it takes the surface to air dry after you have sprayed it with the bleach solution. Bleach can act as a sanitizer in stronger solutions or a disinfectant in a weaker solution. However, remember that fragile skin can be very sensitive to bleach and water solution. If a consumer gets the solution on his/her skin, flush the area with water.

Bleach solution needs to be put into a spray bottle, labeled, and a fresh supply made every 24 hours.

Refer to Home Maintenance and Nutrition sections for further information on cleaning the environment.

Resources:

"Caring for Someone with AIDS at Home"
Centers for Disease Control (CDC)
Divisions of HIV/AIDS Prevention
http://www.cdc.gov/hiv/pubs/brochure/careathome.htm

"**Common Questions and Answers about HIV/AIDS and other Sexually Transmitted Diseases"**
Oklahoma State Public Health
http://www.health.state.ok.us/program/hivstd/q&a/qa1.html#26.

Preventing the Spread of Disease: *Tips for Providers*

Before looking at ways to prevent the spread of disease, it is helpful to know the ways diseases are transmitted. Diseases are caused by germs, which are transmitted from one person to another through

- the air
- urine and feces
- blood
- saliva
- skin
- drainage, such as nasal mucous or pus from open sores

Germs multiply rapidly in warm moist places. When objects or hands touch places where there are a lot of germs, they pick up the germs, which then enter the body through the nose, eyes, mouth, and/or broken skin.

Impetigo and ringworm are transmitted via direct physical contact with the infected areas of skin.

Diseases like colds, chicken pox, and some forms of meningitis are transmitted largely via the air through sneezes and coughs, although they can also be spread through saliva and nasal drainage.

Diarrhea, which generally is a symptom of some gastrointestinal virus, bacteria, or parasite, is transmitted through feces. Some forms of hepatitis can also be transmitted via feces or through urine and blood. Blood and blood products are the major carriers of HIV, the virus that causes AIDS.

Precautions Against Diseases

The precautions necessary to prevent the spread of one disease are the same for another, regardless of whether the disease is life threatening. Because diseases can spread from child to child, from child to care provider, and from provider to child, the same precautions - known as universal precautions - should be used. This is also true whether care is being provided for one child or a group of children, and whether the care is in the child's home, the provider's home, or in a child care setting. Consistently following appropriate procedures also avoids the unpleasant task of singling out a particular child.

The single most important way to prevent infection is frequent hand washing by both the staff and the children. To minimize the spread of disease to everything that is touched, wash the hands with a liquid disinfectant soap for several minutes at the beginning of the shift, and for at least thirty seconds between each child. Hands should be washed:

- after toileting/diapering
- before preparing or eating food
- after handling an animal
- after covering a sneeze or cough
- after blowing the nose

- before and after treating a sore or wound

It is also important to follow these general rules of hygiene:

- Personal grooming articles, such as combs and toothbrushes, and clothing, particularly hats, should never be shared and should be labeled and stored separately.
- Toys and equipment should be cleaned and sanitized frequently, particularly in programs that care for infants and toddlers, who tend to put everything in their mouths.

Diseases that are spread via the air, such as colds, are probably the most difficult to prevent. However, it is possible to control the spread of these germs by:

- providing care in well-ventilated areas
- using disposable tissues and depositing soiled tissues in covered containers
- washing toys and eating utensils thoroughly and frequently
- laundering bed linens between use by different children

Because many diseases can be spread via urine and feces, it is important to:

- Always wash hands prior to and after changing diapers or assisting a child with toileting.
- Wear disposable gloves whenever possible when changing diapers or assisting with toileting.
- Store soiled diapers in a covered container.
- Use a diaper service or disposable diapers whenever possible.
- Disinfect the changing table after each diapering.
- Locate diapering areas and sinks away from food preparation areas.

To prevent the spread of skin infections or blood-borne pathogens like HIV:

- Cover any open sore on either a child or a provider with a bandage.
- Dispose of soiled bandages or other dressings in a covered container inaccessible to others.
- Require permission from a physician before a child with skin eruptions can participate in a group setting.
- Sanitize bed linens before they are used by another child.
- Wear disposable gloves whenever possible when cleaning wounds and applying or changing bandages and dressings.

Healthy Care Providers

During the first six to twelve months of employment, most care providers get sick more than usual, because they are exposed to a wide variety of germs. Caring for others can also cause stress, which lowers resistance to illness.

Care providers can stay healthier by following these guidelines:

- Wash hands properly and frequently.
- Maintain current immunizations, especially tetanus.
- Take scheduled breaks and vacations.

- Observe good nutrition.
- Exercise regularly.
- Rest sufficiently each day.
- Engage in hobbies or other activities that do not involve caring for someone else.

Care providers who are ill should take care of themselves, not someone else, because they cannot provide the usual quality of care and they can spread germs to others. In addition, a person who is ill will take longer to get well if there is not the opportunity to recuperate properly. A healthy care provider is the key to a healthy, happy care experience for consumers and their families.

Summary

Some bacterial, viral, or parasitic infections are contagious even before symptoms appear. Therefore, it is important for care providers to take the necessary steps to prevent the spread of these communicable diseases.

Precautions necessary to prevent the spread of germs are the same for all diseases and should be followed regularly and consistently for every consumer in every setting. The single most important precaution is hand washing. Other universal precautions include properly caring for and cleaning toys, utensils, personal care items, clothing, and bed linens, wearing disposable gloves whenever possible, and properly disposing of articles soiled by bodily fluids.

Resources

American Academy of Pediatrics. (1994). "Children in Out of Home Child Care," in Peter G. (Ed.), *1994 Red Book: Report on the Committee for Infectious Diseases* (23rd ed.) (pp. 79-92). Elk Grove Village, IL: American Academy of Pediatrics.

Washington State Department of Social and Health Services, Children's Administration, Office of Child Care Policy. (1992). *An adult-sized guide to child-sized environments: The child care center licensing guidebook* DSHS 22-733(x). Olympia, WA.

Washington State Department of Social and Health Services, Children's Administration, Office of Child Care Policy. (1991). *An adult-sized guide to child-sized environments: The family child care home licensing guidebook* DSHS 22-808(x). Olympia, WA.

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PRINCIPLES OF CAREGIVING

SECTION X - PERSONAL CARE

X. Personal Care

A. Basic principles
   1. Following care/support plan
   2. Activities of daily living (ADL's)
   3. Consumer dignity and rights
   4. Cultural and religious issues
   5. Observations and reporting

A. Basic Principles

1. Following care/support plan

Individuals, their caregivers and health care providers will develop a care/support plan during an assessment process for DSP assistance based on the functional ability and needs of the individual to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Needing assistance with one or more of the ADLs is usually what health care providers refer to as "personal care needs". As has been mentioned previously, the DSP must follow the agreed upon care/support plan. If the consumer wants you to do something that is not in the care/support plan, you may be opening yourself and the agency to disciplinary and/or liability issues. Contact your supervisor if such a situation arises. Refer to the section on Care/Support plans

2. Activities of daily living (ADLs)

ADLs are considered an individual's fundamental, self-care tasks. They include the ability to:

a. Dress
b. Eat
c. Ambulate (walk)
d. Toileting
e. Take care of hygiene needs (i.e. bathing, grooming)

These five tasks can be remembered with the term "***DEATH"***: ***d****ressing,* ***e****ating,* ***a****mbulating,* ***t****oileting,* ***h****ygiene*.

In addition to ADLs there are the Instrumental Activities of Daily Living (IADLs). These activities are also important for the individual to function in the community and include the ability to:

a. Shop
b. Keep House
c. Manage personal finances
d. Prepare Food
e. Transport (i.e. drive)

These tasks can be remembered with the word "***SHAFT***": ***s****hopping,* ***h****ousekeeping,* ***a****ccounting,* ***f****ood preparation,* ***t****ransportation*

The DSP's assistance in ADLs and IADLs will fill the gap between what the individual can do independently and what the individual needs help with.

This section focuses on the personal care needs (the ADLs) and how to provide assistance to meet those needs. Refer to other sections for information on providing assistance with IADLs.

3. Consumer dignity and rights

Your responsibility is to help an individual maintain normal function or be able to compensate for or regain lost function and to do so in a professional manner that preserves the person's dignity.

Individualizing personal care services enhances the principles of choice and respect. For example, individuals should be empowered to be bathed at the time they desire and the way they prefer. One goal of personal care service is to provide assistance with an ADL, but it is also intended to renew and uplift the spirit.

Consumer rights emphasize respect, choice, and empowerment (controlling what they can control).

4. Cultural and religious issues

DSPs must appreciate the cultural differences between their culture and the consumer's, respect their consumer's culture, and demonstrate that appreciation and respect while providing care. For instance, in the Hindu religion personal hygiene is very important. Bathing is required every day. But bathing after a meal may be viewed as injurious. Do not assume that the way you want something done is the same for the consumer you are caring for. **For input as to cultural and religious issues ask the consumer, other caregivers, and your supervisor.**

DSPs must first possess the core fundamental capacities of warmth, empathy and genuineness. DSPs must have a sense of compassion and respect for people who are culturally different and only then can they learn behaviors that are congruent with cultural competence. Just learning the behavior is not enough. When a person has an inherent caring, appreciation and respect for others they can display warmth, empathy and genuineness.

5. Observations and reporting

--- Refer to the section on Documenting and Reporting

Proper documentation and reporting of personal care tasks is critical. While providing care such as bathing a consumer or applying lotion to a person's feet, the DSP should be **very observant** of any changes in skin condition. If any changes are noted, they must be reported and documented immediately. **It should be documented as to who the report was given to, what action was recommended, and what the outcome of that action was.**

A paid care provider is expected to contact a supervisor who will, in turn, contact the appropriate parties to get the necessary care.

Failing to contact anyone is viewed as negligence and can be grounds for an abuse investigation. Cover yourself against any liability or disciplinary action.

DOCUMENT AND REPORT YOUR OBSERVATIONS

X. Personal Care

B. Assessing and monitoring skin integrity

1. Bruises and cuts

2. Pressure sores

a. Stages

b. Prevention

c. Contributing factors

B. Assessing and monitoring skin integrity

Contact the supervisor before proceeding with any action related to skin problems

Elderly people and people with disabilities are susceptible to skin problems because of decreased mobility due to medical conditions, pain, depression, confusion and/or injury. **Therefore, it is critical for a DSP to routinely check a consumer's skin for any changes and report any changes to his/her supervisor.** Early intervention is of utmost importance in maintaining a consumer's health and decreasing liability of a DSP's and agency.

1. Bruises and cuts

A bruise is a common skin injury that results in a discoloration of the skin. Blood from damaged blood vessels deep beneath the skin collects near the surface of the skin resulting in what we think of as a black and blue mark.

a. Unexplained bruises that occur easily or for no apparent reason **may indicate a bleeding disorder**, especially if the bruising is accompanied by frequent nosebleeds or bleeding gums.
b. Often, what are thought to be unexplained bruises on the shin or the thigh, for example, actually result from bumps into a bedpost or other object and failing to recall the injury.
c. Bruises in elderly people frequently occur because their skin has become thinner with age. The tissues that support the underlying blood vessels have become more fragile.

An effective treatment is to apply ice (or a frozen bag of peas) for 20 minutes to reduce swelling, thereby reducing pain.

A **cut or laceration** refers to a skin wound. Unlike an abrasion (a wound caused by friction or scraping), none of the skin is missing, the skin is just separated. Besides bleeding other concerns include infection, pain, damage to structures beneath the skin, and future scars.

You can usually stop the bleeding by applying direct pressure over the wound with a clean cloth (or dressing) and elevating the extremity. Washing the area with soap and water will help reduce the risk of infection.

2. Pressure ulcers

Pressure ulcers (also called pressure sores or decubitus ulcers) are defined as lesions caused by unrelieved pressure resulting in damage to underlying tissue. Pressure compresses the tissue which causes decreased circulation. This can lead to decreased oxygen and nutrients and ultimately the death of the tissue. Common problem sites are where there is a bony prominence (i.e., tailbone, heels, and elbows). The most common sources of pressure that result in ulcers are:

- Sitting or lying in one position too long
- Rubbing casts, braces or crutches
- Wrinkled bed linens and poorly fitting clothes

a. Stages

Stage I: The skin is reddened and the color does not return to normal 20 minutes after the pressure is relieved. The skin remains intact. In individuals with darker skin, discoloration of the skin, warmth, edema, or hardness may be indicators.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and looks like an abrasion, blister, or shallow center.

Stage III: Involves the full thickness of the skin, extending into the underlying tissues. This layer has a relatively poor blood supply and can be difficult to heal. The ulcer is a deep crater with or without undermining (tunneling) adjacent tissue.

Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures.

b. Prevention

1. Avoid prolonged exposure: Remind or help the consumer to change position at least every 2 hours. (If an area stays inflamed for more than 5 minutes, reduce time for changing position by 30 minutes). Shifting positions redistributes pressure onto other areas. The consumer should relieve pressure on the tailbone (from sitting or lying) every 20-30 minutes by pushing up with arms, shifting from side to side, or leaning forward with feet on the floor. Supervise this procedure to ensure that the consumer does not fall. Encourage mild exercise and activities that do not involve sitting for long periods of time.
2. Avoid skin scrapes from friction: Consider the following to prevent these scrapes:
   - Follow safe transfer procedures. Do not drag or slide a consumer across supporting surfaces. Get help or use a lift sheet to turn and move a consumer in bed.
   - Do not elevate the head of the bed more than 30 degrees. This will prevent sliding in bed and reduce pressure on the tailbone.
   - Prevent the consumer from sliding down in the wheelchair.

- Be sure bedding and clothing under pressure areas (tailbone, elbows, and heels) are clean, dry and free of wrinkles and any objects.
- Watch for skin problems around rings and other jewelry. Jewelry, if too large, can rub the skin. Moisture can get trapped underneath jewelry, especially rings and watchbands.

3. **Protect skin over protruding bones and where two skin surfaces rub together:** Protect the skin with clothing and special pads for elbows and heels. Remember, cushions do not replace frequent positions changes.
4. **Protect fragile skin from being scratched:** Keep fingernails (yours as well as the consumer's) and toenails short. Long toenails can scratch the consumer's legs.
5. **Protect skin from moisture and irritants:** Keep skin dry. Be aware of moisture sources, including baths, rain, perspiration and spilled foods/fluids. Watch for skin irritation from detergent residues left in clothing and bedding.
6. **Watch for allergic reactions (rashes) from health and personal care products:** For example, some persons are allergic to incontinence pads.
7. **If you see an area is reddened, provide a light massage** around, not on, the reddened area, to increase circulation to the area.

c. Contributing factors—(in addition to the information listed above)

1. **Friction:** Friction occurs when a person's body rubs against a surface or an object rubs against the skin. A consumer's skin can be scraped when the person is transferred incorrectly. For example, sliding a consumer can scrape or scratch dry, tender skin.
2. **Moisture:** Prolonged exposure to moisture from sweating and incontinence changes the protective nature of skin and increases the risk of rashes or fungal infection. Damp skin becomes swollen, soft and irritated, making it susceptible to sores.
3. **Dehydration and Poor Diet:** Adequate fluid intake is essential to maintaining healthy skin. Water and foods rich in protein and vitamins (especially vitamin C and zinc) help the body resist trauma, fight infection and promote healing.
4. **Body Weight:** Being particularly overweight or underweight increases the risk of skin problems.
5. **Illness:** Diabetes, heart disease and poor circulation increase the risk of pressure sores.
6. **Limited Mobility and Awareness:** A consumer's willingness and ability to engage in activities may be reduced by pain, sedation, low energy, or motor or mental deficits. The person may ignore warning signs of skin injury or irritation.
7. **Irritants:** Chemicals (including urine) and other substances (i.e., some soaps) can irritate and inflame the skin. Allergic reactions can produce rashes. A skin ulcer can form at the site of irritation.
8. **Injury:** The risk of skin breakdown increases at the site of an injury. A burn from a heating pad, a scratch, bruise or scrape can develop into an ulcer if not properly treated.
9. **Smoking:** Persons who smoke usually have decreased circulation and heal slower.

X. Personal Care

- C. Bathing, dressing, and grooming
  - 1. Skin care
  - 2. Bath/shower (bed, tub, shower)
  - 3. Hair care
  - 4. Dressing
  - 5. Shaving
  - 6. Nails and feet
  - 7. Assistive devices
- D. Oral hygiene

C. Bathing, dressing and grooming

1. Skin Care

In general, skin care involves **good hygiene, good nutrition, exercise, and preventive measures (Refer to preventative measures on page 5 of this section)**. It is important to regularly inspect the consumer's skin for signs of infection or breakdown**. As mentioned before, prevention is better than treatment and a DSP needs to be observant to reduce the risk of problems later on.**

Skin Care Tips: (do not use on open skin lesions without getting supervisor approval)

1. **Aloe Vera gel** (the green gel in the first aid aisle—not lotion) is **very good** to use on minor skin irritation such as chafing that people can get between their legs, groin folds, or under their breasts—use as directed.
2. If a woman does not wear a bra and has large breasts, use a clean piece of 100% cotton material such a man's hankie or piece of undershirt and place under the woman's breasts after her shower. It will help to keep the skin dry.
3. **Gold Bond Medicated Powder** may also work well on minor skin irritation.
4. Use lanolin based soap instead of antibacterial or heavily scented soaps. A rinse less soap works well also.

2. Bathing

Bathing provides many benefits, such as:

a. Cleansing and removing wastes from the skin
b. Stimulating circulation
c. Providing passive and active exercise
d. Helping a person feel better about him/herself and his/her appearance
e. Providing an opportunity to observe the skin, and an opportunity to build rapport

Some consumers may be able to bathe without help; others may need assistance occasionally, or all of the time. **Encourage as much independence as possible**.

How often a consumer bathes will probably be between you and the consumer, although a minimum of once a week is recommended. When considering the frequency of bathing realize that every time an individual bathes he/she washes off natural oils making the skin drier. The consumer's bathing patterns, skin type, recent activities and physical condition will all be factors.

Provide for safety and comfort:

a. Be sure the room is warm and draft free.
b. If you start the bath or shower, use your inner wrist to test the temperature of the water. Water should be moderately warm (not over 105°F) because hot water dries the skin and can result in severe burns.
c. Use non-skid decals or a non-slip bath mat in the tub and shower.
d. A closed toilet seat covered with a towel can serve as a chair**.**
e. Be sure grab bars are installed correctly and assist the consumer in using them.
f. Use a sturdy shower chair or transfer bench.
g. **Ask if the person needs to use the toilet before bathing**. Assist the person to the toilet or commode, or offer a bedpan or urinal, if appropriate. Wear disposable gloves if you will be in contact with body fluids. Wash hands after assisting with toileting.
h. **Be ready to provide assistance**. A consumer may need help getting into and out of the tub or shower, in washing the back or hair, or in towel drying. When a person bathes independently, keep the door unlocked, and check on them about every five minutes.
i. **Explain briefly what will be done and why**. Do not let your explanation turn into an argument about the need for a bath or shower.
j. **Encourage a consumer to perform as much of the bathing routine as possible**. Bathe from top to bottom, front to back. After bathing, assist the person to the towel covered toilet seat or wheelchair and dry lower portion of body. Always be aware of the room temperature and assist in keeping the consumer warm.
k. **Provide for privacy**. Be in the room only when the person needs assistance or supervision.
l. **Examine the consumer's body for signs of skin problems**. Shoulder blades, elbows, tailbone and heels are all prone to pressure sores. Look for reddened areas, breaks in skin or other signs of trauma or infection. Report and document your observations.

Note--Tub baths are not recommended for people with disabilities or elderly persons because it increases the risk of falls or of not being able to get out of the tub. There are instances where individuals have been unable to lift themselves out of a tub and have had to spend hours and sometimes days in the tub until someone rescues

them. Getting into the tub is not as difficult as getting out since getting out requires you to work against gravity on a slippery surface.

A rule of thumb: If a consumer cannot get in and out of a tub without assistance, then a shower should be done using a shower seat. This is safer for not only the consumer but the DSP as well.

Giving a bed bath—If at all possible, have the person sit at the bedside to allow for a change in position. A bed bath is appropriate when a consumer is restricted to bed. The following routine is recommended for giving a bed bath:

a. **Follow a schedule that you and the consumer have agreed upon**. Be as flexible as possible. If the person seems upset or overly tired, suggest an alternative time, if feasible.
b. **Have all supplies ready.** They should include:
   - Wash basin filled with warm water (not over 105 °F)
   - Lanolin based soap (rinse less soap works best)
   - Powder (non-perfumed), lotion or cream. (Lanoline products that do not contain alcohol are recommended), deodorant
   - Comb or brush.
   - Bath blanket, two soft washcloths, two soft absorbent towels
   - Disposable gloves
c. **Raise bed to high position**, if possible, to reduce your back strain. The consumer should be on the side of the bed closest to you. Be sure to use good body mechanics if you need to assist the person in moving. Having a hospital bed is a good idea if the bed baths are being done on a long-term basis.
d. **Cover consumer with the bath blanket (or two beach towels)**, then remove bedding underneath. A bath blanket protects the person from unnecessary exposure and drafts.
e. **Assist the consumer to remove clothing, eyeglasses, and jewelry.**
f. **Talk the consumer through each step of the bath**. Before you begin the bath, explain what you plan to do. Project a professional, caring attitude. This will help relieve any discomfort you or the other person might feel.
g. **Be careful not to overtire a consumer**. Having a bed bath can sometimes be exhausting for a consumer. Pay attention to how the person is responding, and ask them how they are. If a person becomes too tired, finish up with the most important areas (face, hands, arm pits, and genitals) and leave the rest for another day.
h. **Follow a standard routine in bathing the consumer**. Wash, rinse and pat dry one part of the body at a time. Bathe the body in this order: face (eyes first), neck, ears, hands, arms, underarms, chest, abdomen, legs, back and genital area. Encourage the person to do as much as possible to wash self. Look for skin changes (i.e., redness or sores) and report any changes.

In giving the bed bath, follow this procedure:

a. Use one washcloth for cleansing and another for rinsing (unless a rinseless soap is used). Do not scrub or rub, as this might bruise or abrade older skin.
b. Have the consumer wash his/her face or if able. Make sure the areas behind the ears get washed and dried.

c. Place towel lengthwise across chest and abdomen. Fold the sheet down to just above the pubic area. Lift up the chest towel just enough to expose the chest and abdomen and wash, rinse and pat dry the area. Re-cover the chest and abdomen with the towel again.
d. Change water before you wash the legs and back.
e. Place towel lengthwise under the consumer's leg. Wash, rinse and pat dry the leg and foot. Make sure area between the toes is dried. **Check the heels for any signs of skin problems.**
f. Repeat the same process on the other side of the body.
g. Turn the consumer on the side away from you. Place a towel lengthwise close to back. Beginning at shoulders and working down toward buttocks, wash, rinse and pat dry the back. Examine area of tailbone for skin problems (this is a common problem site).
h. Turn the consumer on back. If the person cannot wash the genital area, do it for him or her, always wiping from genital to anal area (front to back).
i. Apply moisturizer while the skin is still moist. Gently massage bony prominences (i.e., hips, tailbone, elbows) using a light circular motion. Do not massage legs—poor circulation often causes clots to form, which can be dislodged by massage.
j. Care for the hair and nails, if needed.
k. Assist the consumer in dressing.
l. Make the bed while the consumer is sitting in a chair.

Peri-care — cleansing the genital area

Female: Have the woman lie on her back with knees bent. Visualize the area and separate the labia. With a washcloth make one swipe from front to back. Turn over the cloth and make another swipe from front to back. Continue until the area is cleansed. Rinse with water using the same procedure and pat dry.

Male: Have the man lie on his back. If the individual is uncircumcised retract the foreskin. Grasp the penis and with a circular motion cleanse from the tip of the penis to the shaft. Turn over the cloth and repeat from the head of the penis to the shaft. Wash the scrotum. Rinse with water and pat dry. For the uncircumcised male put the foreskin back into the original position.

For rectal area for both female and male: Have the person lie on their side away from you. If necessary separate the buttocks to visualize the anal area. Wipe from the front to the back, turning to a new area of the washcloth after each swipe until the area is clean. Rinse with water and pat dry.

3. Hair Care

Routine hair care involves washing, combing, drying and styling. It can be a very tiring task, even for consumers who are independent in most areas. A consumer may enjoy going to a hair salon or barbershop, or having you assist. Some hairdressers will make house calls, too.

Washing, drying and styling a consumer's hair can take 30 - 60 minutes. Consider scheduling a shampoo on non-bath days to conserve the consumer's energy. A shampoo once a week or every two weeks is appropriate for an older person.

A shampoo can be given in the tub or shower, at the sink, or in bed. Where the hair is washed will depend on what is appropriate for, and desired by, the individual. The consumer's health, mobility, energy level and personal preference should be considered. Always consider the consumer's wishes when determining a style. It should be easy to care for and appropriate for the person. The consumer's own styling equipment (e.g., styling brush, curlers, hairpins) should be used.

If you assist with hair care, have the needed supplies ready:

a. shampoo, cream rinse or conditioner
b. a plastic container (for rinsing)
c. towels
d. comb, brush, and possibly a hair dryer

Caution: If the consumer has as eye disorder or has had recent eye surgery, consult a health care professional before proceeding with a shampoo, as moving the head into various positions might cause increased pressure on the eye.

4. Dressing

The key to assisting with dressing, as with any of the personal hygiene and grooming tasks, is for a DSP to allow a consumer to be as independent as possible, even if the consumer dresses slowly. To assist with dressing, follow these guidelines:

a. Gather the clothing first by assisting with laying out the clothing in an orderly fashion.
b. **If the consumer has a stronger and a weaker side, put the clothes on the weaker arm and shoulder side first, then slide the garments onto the stronger side. When undressing undress the strong side first.**
c. Try to assist the consumer with dressing with the consumer in the seated position as much as possible. Put on underwear and slacks only up to the consumer's thighs. Then, with the consumer standing, pull up the underwear and slacks at one time.
d. Encourage the consumer to wear clothes with elastic waistbands and Velcro closures.

5. Shaving

For most men, shaving is a lifelong ritual, and they are able to perform this task in later life despite impairments. The act of shaving, as well as the result, usually boosts morale. A male consumer should be allowed to shave himself unless it is unsafe for him to do so. A female consumer may desire to have leg, armpit or facial hair shaved.

An electric razor is easiest and safest to use. Consumers who have diabetes or who take anticoagulants should use an electric shaver.

After shaving with the electric shaver, rinse the face with warm water or place a warm wet washcloth over the face and pat dry. If the consumer desires, apply after-shave lotion.

6. Nail care for both fingers and toes

Nail care prevents infection, injury, and odors. Hangnails, ingrown nails, and nails torn away from the skin cause skin breaks. Long or broken nails can scratch the skin or snag clothing. Nails are easier to trim and clean right after soaking or bathing. Nails are trimmed with nail clippers, not scissors. **Some agencies do not allow their staff to clip nails** because using clippers can cause damage to surrounding tissue.

Contact the supervisor before clipping nails since this is such a liability risk

Do not trim nails if a person has:

a. Diabetes
b. Decreased circulation to the legs and feet
c. Takes drugs that affect how the blood clots
d. Has very thick nails or ingrown toenails

In these cases, nails should be filed only to prevent possible cutting of the skin. If more care is required, a podiatrist should be consulted (usually covered by insurance for the cases listed above).

When you are giving nail care you should follow this procedure:

a. Explain the procedure to the consumer.
b. Collect the following: wash basin with warm water, nail clippers, orange stick, emery board or nail file, lotion or petroleum jelly, and paper towels.
c. Arrange items next to the consumer. Allow the person to soak nails for 10-20 minutes or perform procedure after bath. Clean under the nails with an orange stick.
d. Clip nails STRAIGHT ACROSS with the nail clippers if allowed to do so. Shape fingernails with an emery board or nail file.
e. Apply lotion or petroleum jelly to hands and feet.
f. Clean and return equipment and supplies to their proper place. Discard disposable items.

Soaking the Feet/Assisting with Foot Care

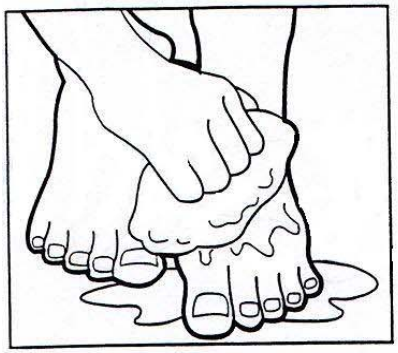
Soaking the feet can help a consumer in three ways: it promotes relaxation, provides exercise, and allows for a DSP to examine the consumer's feet. **Caution: Soaking is not advisable for all consumers.** *Those with diabetes should not soak their feet.* Consult your supervisor to be sure this procedure is recommended. General guidelines for soaking and caring for feet are:

a. Encourage consumer to soak feet. If daily soaks are not realistic, schedule soaks on no bath days. The consumer can soak the feet while sitting and doing grooming tasks or while watching TV. The foot soak should not last more than 20 minutes. Provide a basin of warm water and mild soap.
b. Remind the consumer to exercise feet while soaking. Give step-by-step instructions: Wiggle the toes, stretch the feet, rotate the ankles clockwise, then counterclockwise, flex and extend the toes and ankles
c. Pat feet dry. Dry thoroughly between the toes.
d. **Examine the feet. Look carefully, especially if the consumer limps, resists walking or paces (increased friction may cause blisters or pressure sores)**. If any lesions are noted contact your supervisor for further instructions.
e. Apply lotion to dry, cracking skin. Use a lotion containing lanolin or mineral oil.

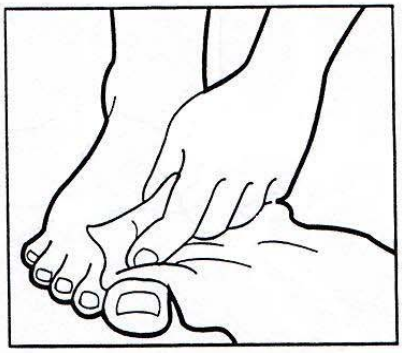
Even though the following addresses foot care for the diabetic consumer, all consumers will benefit from healthy foot care strategies.

Foot Care for People with Diabetes

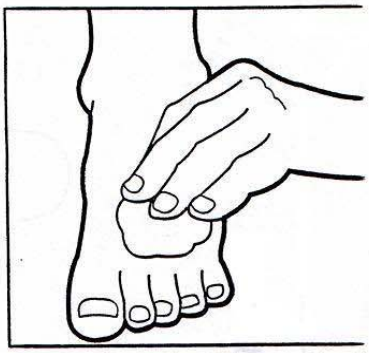
People with diabetes have to take special care of their feet.



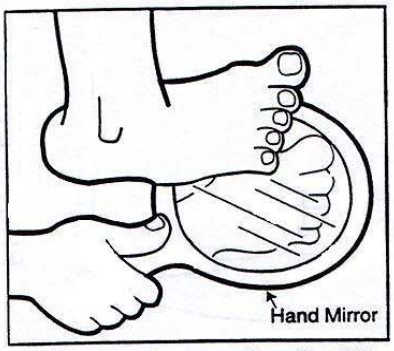
1 **Wash your feet daily** with lukewarm water and soap.



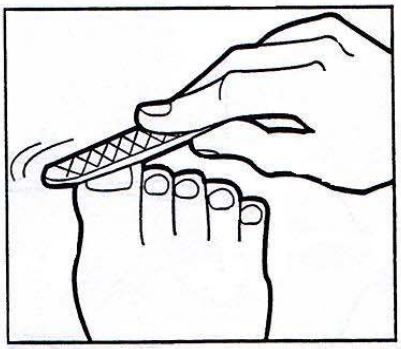
2 **Dry your feet well,** especially between the toes.



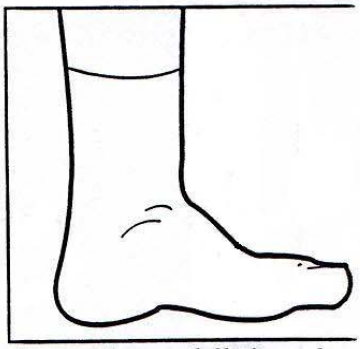
3 **Keep the skin supple** wi a moisturizing lotion, but do not apply it between th toes.



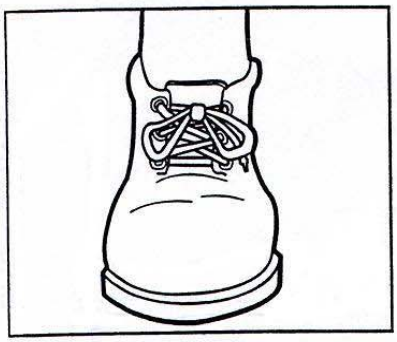
4 **Check your feet** for blisters, cuts or sores. Tell your doctor if you find something wrong.



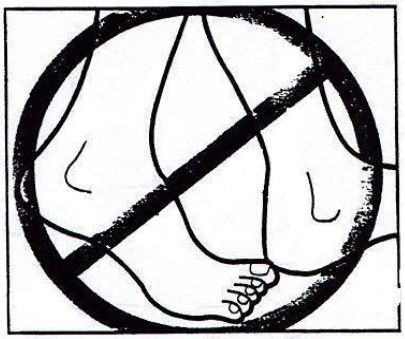
5 **Use emery board** to shape toenails even with ends of your toes.



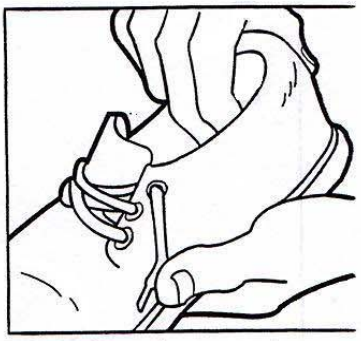
6 **Change daily into clear soft socks or stockings,** not too big or too small.



7 **Keep your feet warm and dry.** Preferably wear special padded socks and always wear shoes that fit well.



8 **Never walk barefoot** indoors or outdoors.



9 **Examine your shoes every day** for cracks, pebbles nails or anything that hurt your feet.

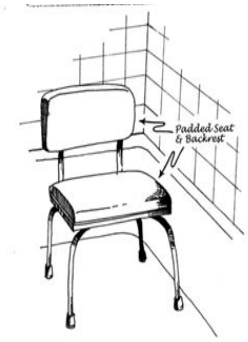
Take good care of your feet - and use them.
A brisk walk every day stimulates the circulation.

7. Assistive devices

Falls in the bathroom are the most common household accident. Wet, soapy tile, marble, or porcelain surfaces in your bathroom can be very slippery. A seat designed for the bath or shower and grab bars allow someone in your home to enjoy safely bathing in comfort. Seats come in different sizes and styles. In any case, look for one that is strong, stable, and has rubber caps on the legs to prevent slipping.

Bath Stool

Economical and lightweight, the bath stool is suitable for a person of slight to medium build. The rubber-capped legs prevent slippage and, with no backrest, allows for easy access to a person's back. The bath stool is ideal for narrow tubs and can easily be stored when not in use. However, its small base contributes to poor stability.



Bath Chair

The bath chair is good for a person with poor back strength and a bigger build (some seats can support up to 400#). While stability is enhanced by rubber-capped legs and a wide base, the bath chair may not fit inside a narrow tub. The backrest hinders easy access to a person's back and other parts of the body.

Transfer Bench

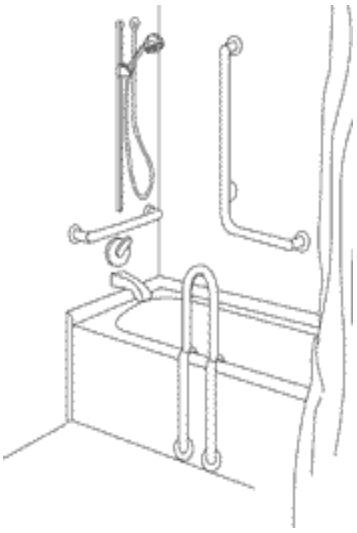
A bench is suitable for those who have difficulty lifting their legs in and out of a tub. The long stationary seat remains partly inside and outside the tub. A person sits down outside the tub, then moves inside by sliding the body across the seat. The suction cups on the height adjustable legs (the inside of the tub is higher than the outside) prevent slippage.

Hand Held Shower Heads

Replace standard shower heads with a hand-held model. This shower head allows an individual to hold the water at the level needed in the shower.

Grab Bars

Installing grab bars in the tub and shower can help a person get in and out more easily and reduce risk of falling. Grab bars are available in a variety of colors and finishes to complement your bathroom decor.



A grab bar near the toilet can give support when sitting down and standing up. If more support is needed, there are a variety of railings that can be added to the toilet itself.

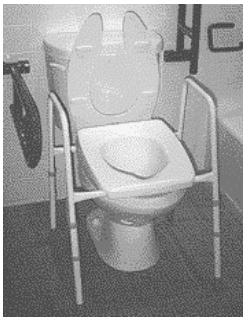
When choosing grab bars, keep these points in mind:

- The diameter of grab bars should be 1 1/4" to 1 1/2". 1 1/4" is more comfortable for most people.
- Textured surfaces provide easy gripping.
- The space between the wall and the grab bar should be 1 1/2" to prevent your arm from being wedged between the wall and the bar.
- To give proper support, grab bars must be mounted securely into wall studs.

Raised or Elevated Toilet Seats

A

B



C

Raised toilet seats assist persons who have difficulty bending or sitting by raising the height of the toilet seat to a more comfortable and convenient height. There are a variety of raised toilet seats to choose from. Some have armrests which provide a sturdy grabbing platform to help with transfers and others are specifically designed for people who are recovering from hip replacement or leg fractures. Some can be attached to the toilet (B) while others are freestanding (A and C). Type A can be tippy and requires the use of grab bars while the other two types are more stable but can hinder how a transfer is done.

When ordering, the person's body build and weight need to be carefully considered. The person must be able to have both feet flat on the floor when sitting on the seat or it is too high.

D. Oral Hygiene

Soft tissues of the teeth tend to harden with the aging process. Pain perception is reduced (painful toothaches are uncommon). Gum tissues recede from around the teeth. Aging dentin, tobacco smoke, food pigments and saliva salts cause discoloration of teeth, ranging from yellow to brown, that cannot be removed by surface cleansing.

Good oral hygiene prevents sores and bad breath, and keeps mucous membranes from becoming dry and cracked. **Poor oral hygiene can contribute to poor appetite and the bacteria in the mouth can cause pneumonia. Inflamed gums also set up an inflammatory process that puts a strain on the heart and decreases resistance to infections**. Encourage consumers to brush their teeth daily, especially at bedtime. Electric tooth brushes or brushes with larger or longer handles promote self-care.

If you assist a consumer with oral hygiene, examine the mouth on a regular basis for signs of redness, swelling, or bleeding. A dentist should check any red or white spots or sores that bleed and do not go away within two weeks.

When you are assisting with oral care, keep these tips in mind:

1. **Brushing should be done at least once a day**. More independent consumers may choose to brush their teeth more often. However, for those who need a great deal of assistance, maintain this minimum.
2. **Have all supplies at hand:** Water for rinsing, towel, basin, soft toothbrush, toothpaste or powder and dental floss. You also need disposable gloves and, if the person has difficulty rinsing his or her mouth, paper towels.
3. **Wash hands and put on disposable gloves**.
4. **Place a towel under the person's chin.**
5. **Have the person rinse mouth with water to remove food particles**. If unable to rinse, gently wipe mouth with a paper towel.
6. **Brush all sides of the teeth with short, gentle strokes, paying special attention to the gum line.**
7. **Brush the tongue and roof of the mouth to remove germs and prevent bad breath**. Be careful not to go too far back or you will cause the consumer to gag.
8. **Have the consumer rinse the mouth with water**. If unable, wipe with paper towel.
9. **Use dental floss to gently clean between teeth**.
10. **If requested, provide mouthwash or rinse.** Mouthwashes are of questionable value. Most contain alcohol, which dries mouth tissue. Their action wears off in one-half to three hours, depending on the strength. If consumers use mouthwash, encourage them to use it only twice daily. You may also water the mouthwash down to lessen its strength and alcohol levels. Routinely change brands to prevent bacteria from building up resistance.

Denture Care

Dentures need to be cleaned at least once a day to prevent staining, bad breath and gum irritation. If you perform this task for the consumer, follow this recommended procedure:

1. **Wash your hands before and after handling dentures, and wear disposable gloves.**

2. Use a tissue or clean washcloth to lift one end, break the suction, and remove the dentures from the person's mouth.
3. **Observe the mouth for loose, broken teeth, sores, swelling, redness or bleeding**. Any of these could indicate improper fitting dentures or a more severe mouth problem.
4. Place dentures in a container filled with cool water.
5. **Clean dentures over a basin filled with water or lined with a washcloth, to prevent breakage should dentures be dropped accidentally.**
6. Cup dentures in hand. Brush the upper inside first, then the tooth and palate area. Rinse thoroughly.
7. Have the consumer rinse before replacing dentures. Provide a mouth rinse such as a saltwater (saline) solution. A warm saline rinse in the morning, after meals and at bedtime is recommended.
8. Apply denture cream or adhesive to dentures before replacing per consumer preference.
9. Store dentures in water when not in the consumer's mouth. This keeps them from warping. Dentures should soak in water for 6 to 8 hours each day (usually overnight).

Partial dentures require the same care as full dentures. When dentures need relining or replacement, they should be repaired by a professional. Home repair of dentures can lead to injury to the consumer's gums.

X. Personal Care

- E. Toileting
  - 1. Incontinence
    - a. Types
    - b. Control
  - 2. Incontinence pads
  - 3. Catheter care
    - a. Indwelling
    - b. Suprapubic
    - b. External
  - 4. Ostomy care
  - 5. Skin care

E. Toileting

Your responsibility is to help consumers maintain normal function or be able to compensate for, or regain, lost function; and to do so in a professional manner that preserve' the person's dignity.

Problems with elimination may occur due to a variety of reasons. Age-related changes, emotional stresses, and chronic diseases that disturb mental health, affect nutrition and limit activity are all possible causes. Bowel and urinary problems may be intermittent or may be constant, depending on the cause. The physical and emotional costs of bowel and bladder control problems can include:

a. Increased risk of skin breakdown and infections.
b. Feelings of anxiety, shame, embarrassment, self-reproach and frustration.
c. Decreased sense of control, dignity, and self-esteem.
d. Concern about the future.
e. Threatened image as an adult.
f. Loss of privacy to perform private functions.
g. Social isolation.

1. Urinary Incontinence

Urinary incontinence is the involuntary leakage of urine, regardless of the amount. Common bladder problems can be caused by reduced bladder capacity, a weakened bladder sphincter muscle, and decreased bladder muscle tone are all common. Other bladder control causes can be:

- **Neurological changes**. Nerve signals to the brain that the bladder is full are slowed, giving the person less time to reach the bathroom.

- **Mental impairment**. For example, memory loss can affect a person's ability to find the toilet and remember proper toileting procedures.
- **Psychological changes**. Depression, stress and fatigue can reduce the individual's motivation and ability to remain continent.
- **Infection.** Bladder infections are common among women.
- **Medications.** Diuretics increase urine output. Sedatives reduce awareness of the need to urinate.
- **Alcohol**. Alcohol increases urine output and reduces awareness of a full bladder.

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a. Types of incontinence -- The four major types of urinary incontinence are:

- **Stress Incontinence**: leakage of urine during exercise, coughing, sneezing or laughing.
- **Urge Incontinence**: Involuntary bladder contractions or the bladder sphincter opens with a sudden urge to urinate. The time between the brain sending the urge signal and the bladder sphincter opening is shortened leading to less time to make it to the bathroom.
- **Overflow Incontinence**: Leakage of small amounts of urine from a constantly full bladder. This commonly occurs in men who have enlarged prostate glands and people who have diabetes.
- **Functional Incontinence**: Problems with the functional or physical ability to get to the bathroom in time. It commonly occurs with conditions such as stroke, memory loss and Parkinson's disease. Persons who have normal control are not considered incontinent if a mobility disorder keeps them from reaching the toilet before urinating.

b. Control of incontinence

1. **Establish toileting schedule every two hours.** Schedule trips to bathroom 10-15 minutes before the typical time incontinence usually has occurred in the recent past. Emptying the bladder before the urge allows more time to get to the bathroom.
2. **Identify care you need to provide**. For example, if access to the bathroom is a contributing factor, list steps you need to take to correct the situation (e.g., provide the consumer with a urinal or commode in the room, and label the bathroom door so that a confused consumer can identify it). Additionally, include interventions that may help a consumer (i.e., positioning, increased fluid intake, and exercise). The following practices are safe in most situations:
   - **Encourage the use of a toilet or commode** instead of bedpan.
   - **Recommend the consumer wear clothing designed for easy removal**.
   - **Remind in an appropriate manner.** For example, use words in the consumer's vocabulary. A memory-impaired person may remember childhood terms such as "potty." If such terms are used, be sure everyone understands this is not meant to demean the consumer, but rather to help.
   - **Provide plenty of fluids**, unless doctor's orders say otherwise. A full bladder sends stronger messages to the brain. Also, adequate fluids dilute urine, making it less irritating to the bladder wall. Offer a glass of prune juice at bedtime if constipation is a problem.
   - **Encourage complete emptying of bladder** before bedtime and immediately after getting up in the morning.

2. Incontinence pads

Incontinence pads help manage bladder and bowel incontinence. There are many different types of pads on the market. If the consumer is unhappy with a certain type, try others before giving up.

In assisting with changing a pad the DSP should gather supplies (new pad, plastic bag, and cloth or disposable wipes for cleansing the skin). The DSP should put on gloves and assist in removing the old pad. Put the soiled pad into the plastic bag. Assist the consumer in cleansing the peri area (the skin needs to be cleansed of urinary and fecal enzymes that will break down skin). Place any soiled disposable wipes in the plastic bag. Assist in applying a new pad. Peel off gloves and toss into plastic bag. Tie bag and take to outside trash. Wash hands.

3. Catheter care

a. Indwelling ("Foley")

The major responsibility is to reduce the risk of urinary tract infections. This is achieved by cleanliness in maintenance of the catheter, tubing, and drainage bags and by proper positioning of the tubing and drainage bags. Routine catheter changes are done by a nurse but it is the responsibility of the DSP to notify a supervisor/nurse of any changes in the urine or complaints of pain. The guidelines for care are:

1. Make sure urine is allowed to flow freely. Tubing should not have kinks or have anything obstructing its flow.
2. Keep the drainage bag below the level of the bladder while in bed, using a walker or wheelchair. Do not attach the drainage bag to the bed rail.
3. Do not set the drainage bag on the floor as this can contaminate the system.
4. Coil the tubing on the bed. Keep the tubing above the drainage bag.
5. Secure the catheter to the inner thigh with tape or catheter strap to reduce the friction and movement of the catheter at the insertion site.
6. Check for leakage of urine and report findings to your supervisor.
7. Cleanse the catheter insertion site when giving daily peri care and if needed after bowel movements and vaginal drainage using the procedure outlined below.
8. Drain the drainage bag in the morning and before bedtime and as needed.
9. Report any complaints of pain, burning, irritation, the feeling of a need to urinate or any changes in urine characteristics such as color, clarity, and odor to your supervisor

To cleanse the catheter at the insertion site follow the procedures as listed for peri care:

Separate the labia (female) or retract the foreskin (male). Check the catheter site for crusts or abnormal drainage. Holding the catheter in place with your fingers, cleanse the catheter from the meatus (urethral opening) down the catheter about four inches. Use soap and water. Avoid tugging on the catheter. Make sure the catheter is secured properly and continue with any further peri care. Replace the foreskin on a male to the original position.

To empty the drainage bag:

1. Get the container that is used for this purpose (can be a urinal or deep plastic bowl).
2. Unhook and open the clamp over the container (be careful not to touch the clamp on the side of the container).
3. Drain the urine into the container, close the clamp, and refasten it to the urine bag.
4. Empty the contents of the container into the toilet.
5. Rinse the container and pour the rinse water into the toilet and flush.

b. Suprapubic

A suprapubic catheter is inserted through an opening in the lower abdomen to the bladder to drain the urine. The catheter is then attached to a urinary drainage bag or a leg bag. The care remains the same as for the care for an indwelling catheter listed above.

c. External

An external catheter (also referred to as a buffalo, Texas, or condom catheter) is applied like a condom to the male's penis and then attached to a urinary drainage bag or leg bag. The tip of the penis should not rub on the interior of the catheter. The catheter needs to be changed every 24 hours and the penis washed and pat dried before applying a new catheter.

4. Ostomy care

An ostomy is a surgical opening in the abdomen through which waste material discharges when the normal function of the bowel or bladder is lost. An **ileostomy** is an opening from the small intestine (ileum portion), and a **colostomy** is an opening from the large intestine (colon). Both types discharge feces. A **urostomy** is an opening to bypass the bladder and discharge urine.

The care and management of the ostomy depends on what type it is. In such cases, the person wears a plastic collection pouch adhered to the abdomen at all times to protect the skin and collect the output. When a new pouch is needed, the skin is cleansed with soap and water, a protective skin barrier may be applied, and a new pouch is applied (may have to be precut to fit the stoma opening). The pouch is emptied at the person's convenience. Again, how the pouch is emptied will depend on the type of ostomy and the supplies used. Some colostomies can be controlled by irrigation (enema) and only require a small gauze pad or plastic stick-on pouch to cover the stoma between irrigations.

There are different types of ostomy supplies on the market and each consumer will have individualized needs for ostomy care depending on the type of ostomy and the size of the stoma (opening) and personal preference. Notify your supervisor if ostomy care is needed.

Remember to wear disposable gloves when giving ostomy care.

5. Skin care

Skin care after toileting assistance is extremely important. As has been mentioned previously the enzymes contained in urine and fecal matter can cause skin irritation and rashes not unlike diaper rashes in infants. For consumers who are incontinent a daily shower is advisable.

It may also be necessary if the consumer wears incontinence pads (do not use the term “diapers” unless the consumer is an infant) to apply some type of skin protectant to the buttocks and peri area such as A&D ointment.

It is also important for the DSP to wear gloves during catheter and ostomy care and wash your hands before and after removal of the gloves.

Note: More detailed information can be found in *Colostomy Guide*, a publication of the United Ostomy Association. Contact UOA at 1-800-826-0826.

X. Personal Care

F. Transferring, ambulation, and positioning

1. **Principles of body mechanics for back safety**
2. **Transferring**
   a. **Gait/transfer belt**
   b. **Mechanical lift**
3. **Walking (ambulation)**
4. **Turning and positioning**
5. **Other assistive devices**

F. Transferring, ambulation, and positioning

1. Principles of body mechanics for back safety

Using correct body mechanics is an important part of a DSP's job because:

a. The individual with a disability depends on the DSP for hands-on assistance and if the DSP does not take care of his/her back with the correct body mechanics, the DSP will not be able to provide that much needed assistance.
b. Not using correct body mechanics puts the safety of the consumer and DSP at risk.
c. Some injuries cause permanent disabilities.

Just as lifting, pushing, and pulling loads can damage your back so can bending or reaching while working in an individual's home. As a DSP, you may have witnessed firsthand the pain and misery a back injury can cause. The good news is that you can learn some simple ways to reduce the risk of injuring your back.

Body mechanics principles that play an integral part of this section are:
a. Center of gravity over base of support
b. Principles of body leverage**.** Using leg and arm muscles is important, but so is applying body leverage. Mirror posture of the consumer. Use body as a unit of "one".
c. It is important for the DSP to be aware of center of gravity over base of support in working with a consumer.
d. Safety - remove throw rugs or other obstacles.

At no time should the consumer put their hands around the DSP's neck during a transfer

2. Transferring

Here are a few general guidelines that apply when assisting with any transfer:

a. Use a gait belt secured around the person's waist to assist him/her.

b. Explain each step of the transfer and allow the person to complete it slowly.
c. Verbally instruct the consumer on the sequence of the transfer. (e.g., Move to the front of the chair, etc.).
d. When assisting in the transfer of a person **do not grab, pull or lift by the person's arm joints (elbows, shoulders, wrists) as this can cause a joint injury.**

A move as basic as getting in and out of a chair can be difficult for an individual with a disability, depending on their age, flexibility, and strength. The height and stability of the chair or other sitting surface also plays a role in the successful transfer. A slightly raised seat is preferable to one that is low or deep. A chair that has armrests is also preferable.

If the person is unable to stand or is too weak to stand, the DSP should use a mechanical lift for transfers. If this is not in the care plan or you do not know how to use a mechanical lift, ask your supervisor for instructions on what to do.

Transfers Out of Bed

a. Tell the person what you are planning to do.
b. If it is a hospital bed, make sure the bed is in a low position and the wheels are locked.
c. Assist the person to a sitting position by supporting the consumer behind the shoulders.
d. Have the person scoot to the side of the bed and assist in swinging the legs over the side of the bed.
e. Give time for the person to adjust to sitting up.
f. Make sure the person's feet are flat on the floor and wearing non-skid footwear
g. Assist to a standing position.

Wheelchair Transfer

a. Prepare the chair for the transfer.
    - Place at a 45 degree angle to the bed.
    - **Lock the wheels.**
    - Put the footrests in the up position
    - Swing the footrests to the side or remove.
    - Take off the armrest closest to the bed if possible (or flip back armrest if available).
    - Tell the person what you are going to do.
b. Assist the person to a standing position (place your legs between their legs).
c. Have the person take baby steps to a standing position in front of the chair (the person should feel the chair seat on the back of his/her legs).
d. Have the person put their hand on the armrest.
e. Assist the person to a seated position.
f. Prepare the chair for rolling:
    a. Replace the footrests in their proper position.
    b. Replace the armrest if necessary.
    c. Unlock the wheels

Variations of Techniques

a. Maximum assist – Mechanical lift, gait belt with total assist
    1. Mechanical Lift
    2. Gait belt with consumer who is 50% or less weight bearing
    3. Stand pivot
    4. Squat transfer
b. Moderate assist
    1. Gait belt with consumer who is 50% or more weight bearing
    2. Verbal cues with moderate physical assist
c. Minimum assist
    1. Gait belt optional
    2. Hands on with consumer who is 85 - 90% weight bearing
    3. Verbally & physically guiding consumer
    4. Stand by assist (this is to insure safety)

Transfer from Chair to Walker

a. Tell the person what you are planning to do.
b. Place the walker in front of the person (verbally cue client to put one hand on the center of the walker and the other hand on the surface/armrest of the surface they are arising from).
c. Position yourself in front of the person.
d. Tell the person to scoot to the end of the chair seat.
e. Have the person place his/her hands on the armrests, if the chair has them.
f. Get a rocking movement going.
g. On the count of three, have the person push down on the armrest and assist the person to a standing position by lifting the person around their waist (or use a gait/transfer belt). Use the arms of the chair, not the walker, to assist in lifting.
h. Pull the walker in front of the person.
i. Have the person stand for a minute before walking to adjust to standing position.
j. When sitting, the person should back up until the chair is felt on the back of the legs and reach back to the arms of the chair to provide a safe descent to the seat.

Important Considerations for Effective Walker Use

a. A professional, such as a physician or physical therapist, should help choose or prescribe a walker and then demonstrate how to walk correctly with it.
b. Walker height is best when the arm bends at the elbow in a 20 to 30 degree angle. This is achieved by having the top of the handle of the walker at the same height as the bend of the person's wrist.
c. To prevent tripping or falling:
    - The person should always look ahead, not at the feet.
    - Walk inside the walker (avoid pushing walker to far ahead as if it were a "shopping cart".
    - Use walkers only in well-lit areas.
    - Avoid cluttered and crowded areas, throw rugs, and wires running across the floor
    - Wear appropriate footwear. Properly fitting shoes with rubber soles are best. Do not wear loose fitting footwear such as slippers, high heels, or slippery-soled shoes

- Avoid using the walker on stairs
- Small rooms, such as bathrooms, may prevent safe walker use. A solution is to install grab bars.
- If using a wheeled walker a person may also reverse the wheels so that the wheels are on the inside of the walker, thereby saving 3-4 inches of space

a. Gait/transfer belt use

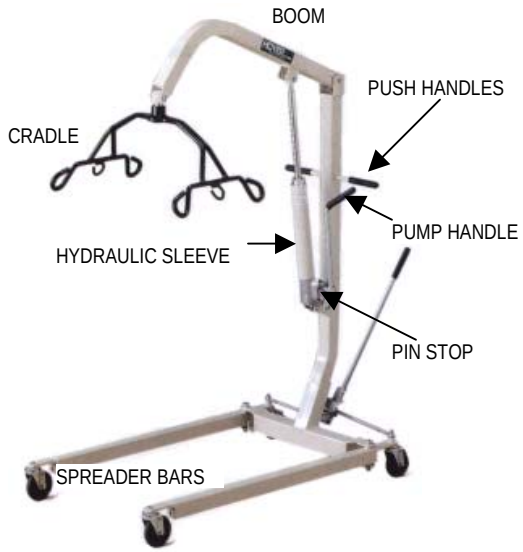
The gait belt is instrumental in providing safe transfers and ambulation for the DSP and the people being served.

Procedure in using a gait/transfer belt
- Tell the person what you are going to do.
- Position the person to make application of the belt possible.
- Secure the gait belt around the consumer's waist. Always secure the gait belt around the waist, on top of clothing. For females make sure breast tissue is above the belt.
- The gait belt should be snug. The DSP should be able to place two fingers in between the belt and the person. Buckle in front.

b. Mechanical lift--<u>Do Not</u> operate <u>any</u> device that you have not been trained to use

A mechanical lift is used to transfer a consumer from a bed to a wheelchair, a wheelchair to a couch, etc. -- **not** to transport from one room to another.

Define and explain all parts of the mechanical lift
- Spreader bars (Open)
- Push Handles
- Caster wheels
- Hydraulic sleeve
- Boom
- Cradle
- Pin stop or wing nut
- Sling types
  - Canvas
  - One piece
  - Commode cut out
  - Mesh
  - Split



Procedure for use of mechanical lift device
- Examine a mechanical lift to make sure the lift is in proper working condition.
- Tell the person step-by-step what is going to be done.
- Have the bed flat when transferring a person from bed to chair.
- Roll the person onto his/her side, away from the DSP and place the smooth side of the sling touching the person. Reinforce correct body mechanics when rolling the person.
- Insert chain hooks from inside the sling to outside so the hooks will not scratch the person.

- Secure the person's arms inside sling. If the person cannot do this themselves, this can be accomplished by rolling the bottom of the person's T-shirt over the person's arm or using a hand towel wrapped around the person's arm as a muff.
- Pump the handle until person is raised just free of the bed.
- Use the steering handle to pull the lift from the bed and maneuver to a chair or maneuver the lift so the wheelchair can be put into the proper position for the lift.
- Slowly release the valve and lower the person while putting your hand on the person's knee and gently move the person so the person is touching the back of the chair. This step will help to achieve good placement on the chair.
- Check to see if the person is positioned correctly on the chair. Unhook the chains and move the lift out of the way.

3. Walking (ambulation)

a. Apply gait belt, unless instructed not to or one is not available.
b. Always walk on the person's weak side.
c. Walk slightly behind the person while holding onto the gait belt from behind and placing your hand under the belt from the bottom versus from the top of the gait belt.

4. Turning and Positioning
(Also refer to prevention of pressure ulcers)

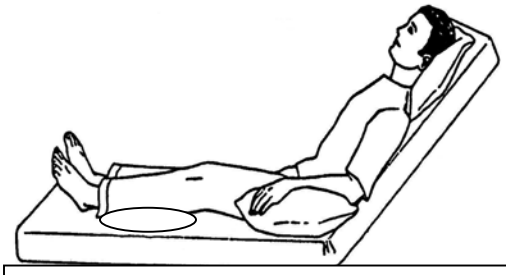
Preventing Contractures

A contracture is a stiffening of a muscle due to immobilization caused by injury or disease. Following a stroke or other injury, muscles can remain inactive for long periods of time. During this period of time, the muscle atrophies and shortens, sometimes to the point that it can no longer be used. Contractures can form in the hands, fingers, arms, hips, knees and calves, as well as other areas where joints remain still for a long period of time. Contractures affect the major joints and surrounding soft tissue

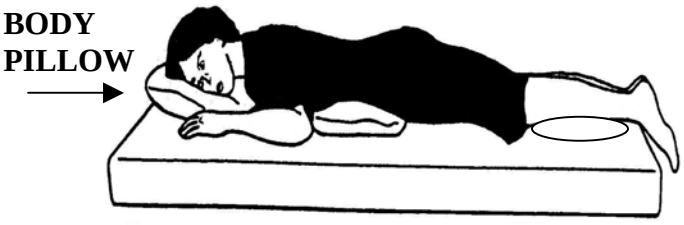
Once a contracture has developed, it can be difficult and painful to treat. It severely restricts a person's movement and independence. DSPs can help prevent contractures through proper positioning, exercise and equipment.

Positioning

When a person with a disability is sitting, make sure they are sitting upright to prevent contractures from forming in the chest muscles and the front of the shoulders. Make sure that both feet are flat on the floor, and encourage the person to keep palms open and down in a relaxed manner, possibly against a table or armrest. This will prevent contractures from developing in the hand. Putting a rolled washcloth in the person's hand may help prevent hand contractures. (In a spastic, contracted hand this helps with hygiene).

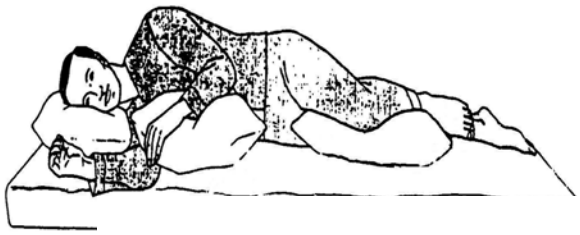


Fowler's Position. Pillows used for alignment

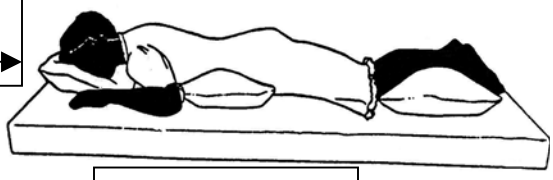


Prone Position w/ feet hanging over

Supine Position



Lateral Position w/ pillows used for support



Prone Position

People who cannot change position need to have the **DSP change his/her position** in bed or in a chair/wheelchair **at least every two hours.**

5. Other assistive devices

Canes

As people grow older important daily activities like walking, dressing, bathing, and eating may become increasingly difficult to manage. Many older people depend on assistive devices to help carry out these activities.

The cane is the most widely used assistive device. In the United States alone, over 4 million people use canes. People who have difficulty walking use canes for stability and balance. Canes support up to 10% - 15% of a person's weight and may prevent falls.

In choosing a cane, metal is preferred over a wooden cane since wood can splinter or crack. The handle of the cane should be as high as the wrist of the hand opposite the person's weak side. While standing and holding the handle of the cane, the elbow should be at a 20 to 30 degree angle. The quad cane, so named because it has four feet, adds more stability to a cane to help the user maintain balance and equilibrium while walking. Tips on the end of cane legs provide traction and absorb shock, thereby cushioning the hand. A convenient option is a wrist strap attached to the handle of a cane allowing the hand to be free without having to set down the cane. It also prevents a person from dropping the cane.

Important Considerations for Effective Cane Use

- Do not use canes on stairs without using a handrail or the support of another person on the opposite side. Most quad canes and other wide base canes are not safe for use on stairs.
- Because they slip easily, do not, in general, use canes on snowy or icy surfaces. However, metal or rubber tips that grip the ice may give more protection against slipping and falling.
- Make sure the cane tips are not worn down. Replacement cane tips are readily available in larger drug stores.

Walkers

Walkers rank second behind canes in amount of users, numbering almost two million people in the U.S. Since their introduction over two hundred years ago, walkers have changed greatly. Able to support up to 50% of a person's weight, walkers are more stable than canes. Walkers are helpful for people with arthritis, weak knees or ankles, or balance problems.

The most basic walker design, the rigid walker is the type most often used in therapy. To operate, a person lifts the walker, moves it forward, and puts it back down with each step. Because they require lifting, extended use may cause strain on the wrists, shoulders, and arms.

Types of Walkers

A. Rigid

B. Wheeled

C. Rolling

Unlike the rigid walker, the user merely pushes the two-wheeled walker (B) forward. No lifting is necessary, so the walking style is more natural. Two-wheeled walkers have automatic brakes that work when you push down on the walker. Some have auto-glide features that allow the rear legs to skim the surface. Three or four wheeled rolling walkers (C) require less energy and strength to use. Gliding over carpets and thresholds is easier, and they may provide better performance in turning. Three and four wheeled walkers often have hand brakes. Wheel size and walker weight vary greatly in different models of wheeled walkers. All are heavier than rigid or folding walkers. Because many wheeled walkers do not fold, they may be more difficult to transport.

Important Considerations for Effective Walker Use

- A professional, such as a physician or physical therapist, should help choose or prescribe and then demonstrate how to walk correctly with the walker.

- Walker height is best when the user's shoulders are level, and the arm bends at the elbow in a 20 to 30 degree angle.

- To prevent tripping or falling, always look ahead, not at the feet and use walkers only in well-lit areas. Avoid cluttered and crowded areas, throw rugs, and wires running across the floor. Wear appropriate footwear. Properly fitting shoes with rubber soles are best. Do not wear loose fitting footwear such as slippers, high heels, or slippery-soled shoes.

- When transferring from a sitting to a standing position, use the arms of the chair, not the walker, to assist in lifting. Once up, be sure there is no dizziness before beginning to walk. When sitting, the client should back up until the chair is felt on the back of the legs and reach back to the arms of the chair to provide a safe descent to the seat.

- Avoid using the walker on stairs. Small rooms, such as bathrooms, may prevent safe walker use. A solution is to install grab bars.

Wheelchairs

Today, older Americans use more wheelchairs than any other age group. As the number of people using wheelchairs grows, so the dimensions, characteristics, and kinds of wheelchairs are becoming more diverse. Unfortunately, many people are not aware of the wide variety of wheelchairs to fit different needs and only know about the standard, heavy-duty wheelchair. Many people pick up wheelchairs from garage sales, or receive them as gifts from well-meaning friends. Unfortunately, this can lead to a poor "fit" between the user and the wheelchair, which can lead to skin problems in the future. To avoid this, it is very important to consult with an expert, such as a physical or occupational therapist, before selecting a wheelchair. People often use wheelchairs for many years and for extended periods a day, so it is important that the wheelchair be comfortable.

The most frequently prescribed wheelchair is the standard wheelchair. Standard chairs are heavy, usually weighing over forty pounds. People who need to transport or store their wheelchairs might prefer lightweight wheelchairs. These lightweight chairs are as much as thirty pounds lighter than the typical standard chair and require less strength and energy to move.

Power or electric wheelchairs are powered by batteries and require much less physical strength to move than standard (manual) chairs. They provide independence for people who are unable to propel themselves in manual chairs. Since these wheelchairs have to carry heavy batteries and power systems, the frames are generally sturdier than manual chair frames. Because of extra equipment, power chairs may be a bit wider, are harder to maneuver in tight spaces, and are very heavy and do not fold. Most power chairs will require a van for transportation. The wheelchair supplier should explain how and when to charge the batteries. With regular use, a battery should last a minimum of one year before replacement may be necessary. As wheelchair batteries differ from car batteries, buy the batteries only from a wheelchair supplier.

Scooters are also powered by batteries and resemble a horizontal platform with three wheels and a chair. Scooters are useful for people who can walk short distances but need help for long distances. Some scooters disassemble easily for transportation in the trunk of a vehicle. When selecting a scooter, check if you can lift the largest, heaviest part when disassembled. This may help determine how transportable it is for you.

Wheelchair Accessories

- Transfer boards, typically made of wood or plastic, make it possible for a wheelchair user to move from the wheelchair to another seat or bed without standing.
- Safety flags are available to make you and your chair more visible to drivers, should you use your wheelchair while crossing streets.
- If you find that your wheelchair runs into walls, one company sells a kit that provides plastic and rubber bumpers and guards that can be attached to the wheelchair, providing protection for the walls.

X. Personal Care

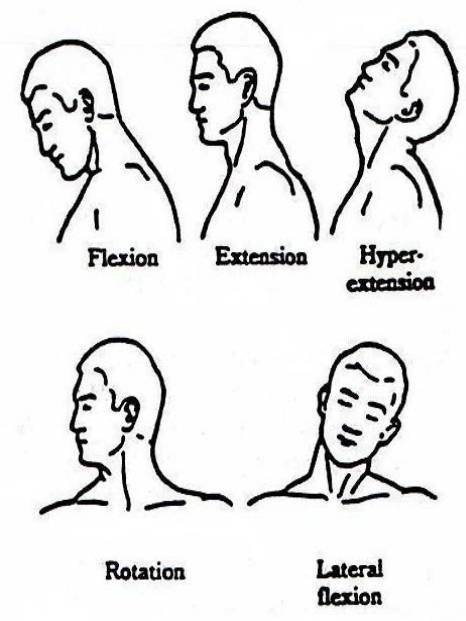
- G. Range of motion exercises
  - 1. Active
  - 2. Passive
- H. Meal assistance

G. Range of motion (ROM) exercises

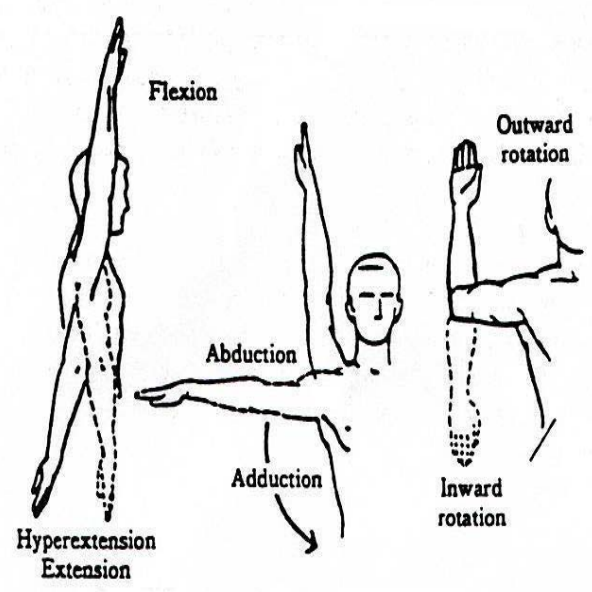
Range of motion exercises are the best defense against the formation of contractures. A physical therapist, home health nurse or other health care professional should recommend helpful ROM exercises for an individual with disabilities to do at home. These exercises will concentrate on the joints. Each motion should be repeated, slowly and gently, and never beyond the point of pain. **Never exercise a joint that is swollen or red.**

Some consumers will be able to do ROM exercises independently with nothing more than encouragement and direction from you. Others will need assistance from you, possibly helping them to lift, stretch and move limbs and joints, or being physically "cued" on how to perform the exercise. Still others, who are very limited physically, may be dependent on you to actually move them through the exercises. Regardless of how much you must be involved, the consumer will benefit from the movement, and it will allow them to maintain more range of motion.

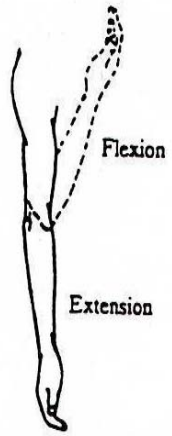
1. **Active ROM**
   Done by the consumer
2. **Passive ROM**
   Done by the caregiver**—Passive ROM exercises should be approved by a health care professional to limit liability**



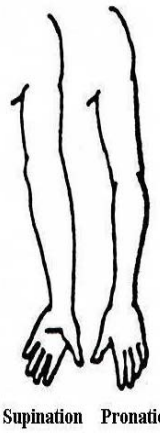
Range of motion exercises for the neck



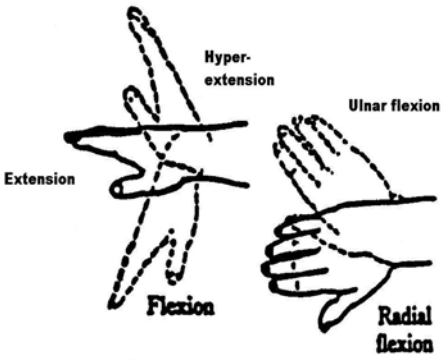
Range of motion exercises for the shoulder



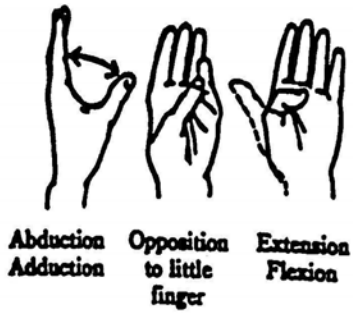
Range of motion exercises for the elbow



Range of motion exercises for the forearms

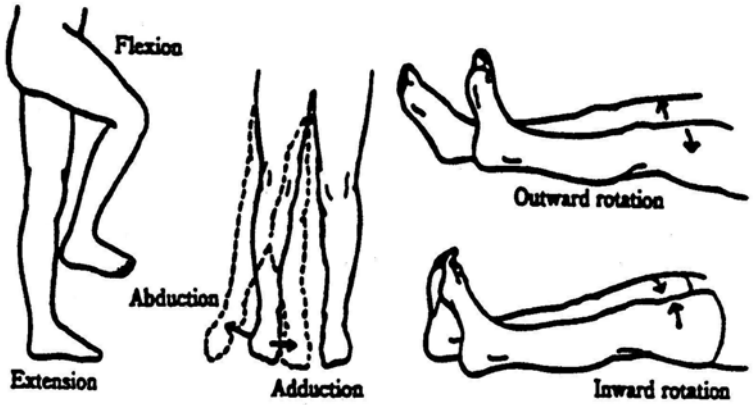


Range of motion exercises for the wrist

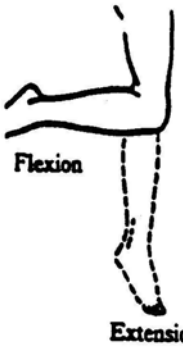


Range of motion exercises for the thumb

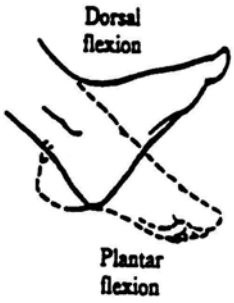
Range of motion exercises for the fingers



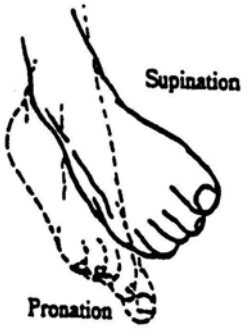
Range of motion exercises for the hip



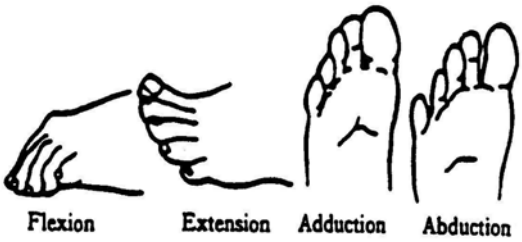
Range of motion exercises for the knee



Range of motion exercises for the ankle



Range of motion exercises for the feet



Range of motion exercises for the toes

H. Meal Assistance (Assisting with eating/feeding)

Adaptive equipment should be available to consumers to encourage self-feeding. Feed a consumer only if he/she is unable to do so. Refer to the section on Nutrition for assistive eating devices.

Assisting with setting up a meal for eating

a. The individual should be sitting with his/her head elevated to prevent choking.
b. Cut meat, open cartons, butter bread if assistance is needed.
c. Use clock description for a person with a vision impairment (i.e. meat is at 12:00; salad is at 4:00, etc.).

Feeding a consumer

a. Use hand on hand to assist a consumer.
b. Check temperatures of foods before feeding. Feel the container and observe for steam.
c. Explain what foods are on plate. Ask the consumer what he/she wants to eat first.
d. Watch the individual to make sure food is swallowed before giving additional food or fluids. It may be required to remind the consumer to chew and swallow.
e. Offer liquids at intervals with solid foods. Use a straw for liquids if the consumer can sip through a straw.
f. Make pleasant conversation, but don't ask the consumer questions that take a long time to answer. Do not rush the consumer as you are assisting with eating. Sitting next to consumer at eye level conveys a non-rushed feeling.

Feeding an individual with dysphagia (difficulty swallowing)

a. Position the person upright in a chair to prevent choking or aspiration (inhaling liquids).
b. Keep the consumer oriented and focused on eating.
c. Help him/her control chewing and swallowing by choosing the right foods (a diet containing food with thick consistency, which is easier to swallow) such as:
    - Soft-cooked eggs, mashed potatoes and creamed cereals
    - Thickened liquids are often used
d. A variety of textures and temperatures of foods stimulate swallowing; vary foods offered from the plate.
e. At times dysphagia is temporary; a consumer who is temporarily ill may have difficulty swallowing, which improves after recovery from illness.

Feeding a cognitively affected consumer

a. Avoid changes. Seat the consumer at the same place for all meals.
b. Avoid excessive stimulation. Too much activity and noise often adds to confusion and anxiety. Remove distractions, if possible, and refocus consumer.
c. Meals should be ready to eat when the consumer is seated (i.e. meat is cut, bread is buttered, etc.).
d. Avoid isolating the consumer; isolation leads to more confusion.
e. Call a consumer by a name he/she prefers. Achieve and maintain eye contact.
f. Use a calm voice; speak softly, slowly, clearly and face the consumer.
g. Keep communication simple; use simple, short instructions such as "pick up your fork," "put food on your fork," "put the fork in your mouth."
h. Use objects or hand movements to help with cueing.

PRINCIPLES OF CAREGIVING

SECTION XI - NUTRITION AND FOOD PREPARATION

XI. Nutrition and Food Preparation

A. Basic nutrition
1. Role and importance of nutrition
2. Essential nutrients
3. Special considerations for consumers
4. Hydration

A. Basic nutrition

1. Role and importance of nutrition

If you have good eating habits and are well nourished, you will have all the nutrients you need for energy and good health. The eating habits of a lifetime can have a great effect on an older person. Many health problems common among older people are related to lifelong diet patterns. These include heart disease, diabetes, stroke, high blood pressure, osteoporosis (thinning bones), atherosclerosis (fatty deposits in blood vessels), and digestive problems. Good nutrition is important in the care of ill and frail persons. **It speeds up healing, recovery from illness, and helps maintain health.**

2. Essential nutrients

Nutrients	Food Sources	Body Uses For:
Proteins	Meat, poultry, fish, eggs, cheese, milk, peas, nuts	Growth and strength, cell repair, builds bones and body tissue
Carbohydrates	Breads, cereals, rice, pasta, potatoes, corn, fruits, sugars, flour	Energy
Fats	Butter, margarine, oil, ice cream, dressings, meats, nuts, mayonnaise	Energy, protection of body organs, nerves, cells
Vitamins	Fruits and Vegetables, butter, milk, liver	Growth, healing, resistance to sickness healthy skin, eyes, teeth, gums, hair and bones
Minerals	Milk, cheese, yogurt, green leafy vegetables, meat, eggs, breads, cereals	Bones teeth, blood, nerves, muscles
Water	Water and other liquids	The human body is made up of 55-85% water. Water carries nutrients to the cells, flushes wastes from the cells, and regulates body temperature
Fiber	Raw fruits and vegetables, whole grain cereals	Digestion, getting rid of wastes

3. Special considerations for consumers

a. **Note any food allergies. Some food allergies can cause anaphylactic shock which can quickly lead to death.**
b. **Note any special diet orders** and plan and prepare the meal according to the dietary restrictions
c. Make sure client uses good oral hygiene and assist if needed. Poor dental hygiene can lead to inflammation of the gums and sensitive teeth causing pain and difficulty with chewing. It also can decrease the person's appetite.
d. Make sure dental appliances such as dentures and bridges fit and are used properly.

4. Hydration

Water is important because it prevents dehydration, reduces stress on the kidneys, and helps maintain regular bowel functions.

An adequate amount of daily water intake is by far the most important of all the dietary requirements for the body and is essential to life. A person may live for several weeks without food, but can only survive for a few days without water. That is because our bodies are 72% water and we lose about 10 cups of water each day through sweating, going to the bathroom, and breathing.

The amount of water we lose each day increases when the temperature is hotter.

Thirst may not be an adequate or accurate indicator of the need for fluids because your body needs fluids before you get the impulse that you are thirsty. Most people should drink approximately 64 ounces (6 to 8 glasses) of fluid per day, with about half of that intake consisting of pure, uncolored, unflavored water.

Increased fluid intake is required for people who:

- Experience heavy sweating/perspiration
- Live in a warm climate
- Use tranquilizers, anti-convulsants, or some behavioral health medications
- Experience heavy drooling
- Experience Urinary Tract Infections (kidney and bladder)

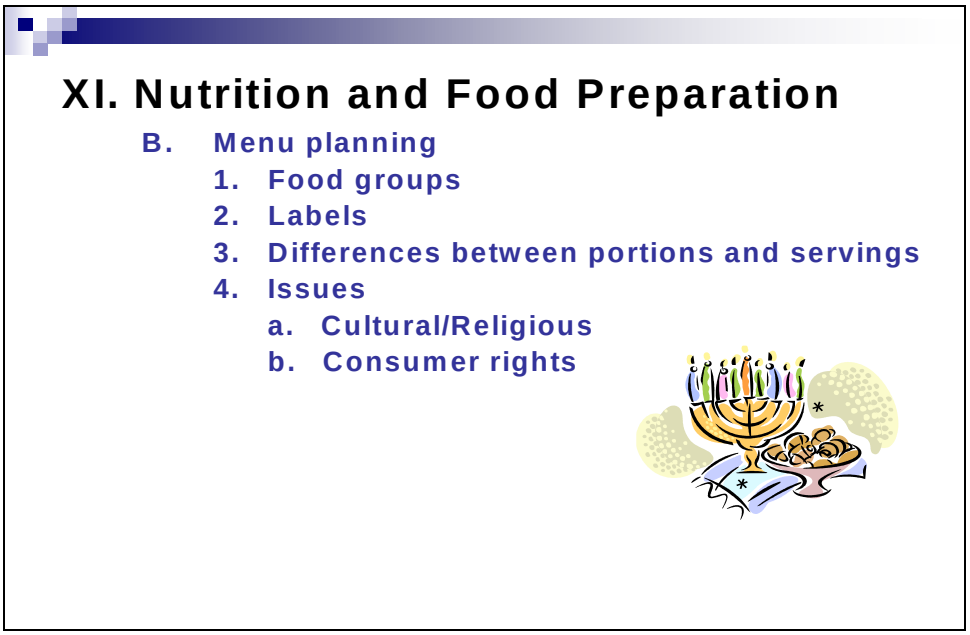
Dehydration: signs and symptoms

- Dry skin, especially around mouth/lips and mucous membranes
- Less skin flexibility/elasticity
- Dark, concentrated urine with decreased urination
- Less/no sweat
- Leads to electrolyte imbalance, delirium, even death if untreated

To encourage an individual to drink fluids:

- Have water within reach, encourage intake
- Use other fluids as well, such as shakes, fruit drinks, soups, puddings, and gelatins
- Avoid caffeine and sugar in fluids, if possible, since caffeine and sugar are dehydrating to the body. If you drink a lot of coffee, cola (even diet cola), and other similar liquids, you need to drink more water than the average person.

People who are on diuretics (“water pills”) often do not like to drink water because they feel it makes them have to go to the bathroom more frequently. However, if you are on a diuretic (often used to treat cardiovascular problems) not drinking enough fluids will send a feedback message to retain fluids making the condition being treated even worse.



B. Menu planning

1. Food groups

- **Breads and cereals** are a good source of fiber, vitamins, and minerals. Whole grain products such as whole wheat bread, oatmeal, and brown rice are good choices. Look for dry breakfast cereals that are low in sugar. Avoid sugar-frosted and candy-coated cereals.
- **Fruits and vegetables** are good sources of fiber and are generally low in fat. Include dark leafy greens and yellow or orange vegetables in the daily diet as these are rich in vitamins, minerals, and cancer-preventing chemicals. Citrus fruits such as oranges, grapefruits, and tangerines, as well as their juices, are rich sources of vitamin C.
- **Proteins, animal** (beef, pork, poultry, fish, and eggs) and/or **vegetable proteins** (beans, lentils, nuts, and seeds) need to be included in the diet daily. Look for lean meats and trim off visible fat.
- **Dairy products,** fat-free and low-fat, are good sources of calcium and protein. Unless being underweight is a concern, choose fat free milk and low-fat cheese. If milk causes diarrhea or gas, yogurt or cheese may be acceptable or try enzyme-treated milk (Lactaid), fortified rice milk, or fortified soy milk.
- **Fats and sweets** can be included in the diet, but should be limited to small amounts. Excess amounts of fats and sweets replace healthy foods in the diet and can lead to tooth decay, obesity, and heart disease.

2. Labels

- Ingredients are listed in descending order by volume of weight. (most to least)
- The number of calories in a serving and the calories from fat are given in numbers.
- Vitamins and minerals are only listed if they are in the food in significant value, at least 1% of the daily requirement.
- Percent Daily Values are based on a 2,000 calorie diet. Many people are on lower calorie diets.
- Total fat, cholesterol, sodium, total carbohydrate and dietary fiber are given both as numbers in grams and percentages of Daily Value. The Daily Values for these essential nutrients set upper limits for people regarding the amount to eat each day to stay healthy.
- You may also want to compare the labels to see which foods are high in fat, good sources of vitamin C, are any high in cholesterol? High in fat? Which has the lowest sugar? Etc.

Reduced Fat Milk (2%)

Nonfat Milk

Note that the amount of nutrients and protein per serving stays the same but the calories, fat percentage, and cholesterol is <u>decreased</u> with the Nonfat Milk

The recommendations for the daily intake of total fat, saturated fat, cholesterol, and sodium are:

- total fat: less than 65 g or 30% of caloric intake
- saturated fat: less than 20 g
- cholesterol: less than 300 mg
- sodium: less than 2,400 mg

Food Label Activity

Reading a Food Label

Directions: Divide into small groups. Each group will be given a food package. Read the food label and answer the following questions. Be prepared to share information from the food label with the class.

Name of Food:_____

1. How many servings does your package contain?

   How many calories per serving?

   When eating this food, do you think a person normally eats more or less than the serving size?

2. What is the main ingredient of your food?
   How do you know?

3. Would you serve this food to someone who is trying to:
   - Reduce his or her cholesterol? Why or why not?
   - Increase fiber? Why or why not?
   - Limit salt (sodium)? Why or why not?

4. What food group or groups does this food belong to on the Food Guide Pyramid?

5. Is this food a good source of any vitamins and minerals? If yes, list them:

3. Differences between portions and servings

Examples of various food serving sizes are listed below. If you eat a larger portion, count it as more than one serving. For example, a restaurant portion of two cups of spaghetti would count as four servings of pasta. Eating a whole bagel from a bakery (usually a large bagel) would equal four servings of bread.

Milk, Yogurt, and Cheese

1 cup of milk or yogurt	1 1/2 ounces of natural cheese
2 ounces of processed cheese	1 1/2 cups of ice cream, ice milk
2 cups cottage cheese	

Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts

2-3 ounces of cooked lean meat, poultry, or fish	1/2 cup of cooked dry beans
2 Tablespoons of peanut butter	1/3 cup of nuts
2 slices of bologna (1oz)	1 egg

Vegetables

1 cup of raw leafy vegetables	1/2 cup other vegetables, cooked or chopped raw
3/4 cup of vegetable juice	10 French fries

Fruit

1 medium apple, banana, orange	3/4 cup of fruit juice
1/2 cup of chopped, cooked, or canned fruit	1/4 whole avocado

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Bread, Cereal, Rice, and Pasta

1 slice of bread	1 ounce of ready-to-eat cereal	1/2 med. doughnut
1/2 cup cooked cereal, rice, or pasta		4 sm. crackers
1/2 small bagel	4” pancake	

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4. Issues

Cultural and Religious Issues: Most people have food they like or prefer to eat and most people have some foods they don’t like and avoid. Some food preferences relate to what each person ate while growing up. Cultural and religious traditions also can influence what foods people prefer to eat or avoid. For example, people of the Muslim faith do not eat pork or in many Asian cultures rice is included with most meals**.**

It’s best to ask and not assume about what someone wants to eat. Typically, the DSP can respond sensibly to preferences, unless whole classes of important foods are ruled out. In that case, seek advice from the individual’s doctor and others such as a dietitian or behavior specialist.

Consumer rights

Consumer rights dictate that the consumer has the choice of which foods he/she prefers to eat and choice of meal times. However, what happens if the consumer wants to eat something that is not on their prescribed diet?

The DSP should try to negotiate with the consumer in order to follow the diet. For example, if the consumer is diabetic and is demanding chocolate cake, maybe the consumer can have a small piece and freeze the rest. If problems still persist or if you have any questions, contact your supervisor.

XI. Nutrition and Food Preparation

- C. Food Safety
  - 1. Preparation
    - a. Cleaning surfaces/dishes/equipment
    - b. Washing/preparing food
    - c. Defrosting meat
  - 2. Storage
    - a. Two-hour rule
    - b. Refrigerator/freezer temperatures
    - c. Open boxes

C. Food Safety

A foodborne illness is a sickness caused by eating contaminated food, sometimes called food poisoning. The very young and the very old are at increased risk for foodborne illnesses due to:

- Immune system is not as efficient.
- Stomach acid also decreases with aging—and stomach acid plays an important role in reducing the number of bacteria in the intestinal tracts

Underlying conditions such as diabetes, cancer treatments, kidney disease, HIV/AIDS, and a history of an organ transplant may increase a person's risk of foodborne illnesses.

To reduce the risk of illness from bacteria in food, individuals who are at greatest risk are advised not to eat:

- Raw fin fish and shellfish, including oysters, clams, mussels, and scallops.
- Raw or unpasteurized milk or cheese.
- Raw or lightly cooked egg or egg products including salad dressings, cookie or cake batter, sauces, and beverages such as eggnog (Foods made from commercially pasteurized eggs are safe to eat).
- Raw meat or poultry.
- Raw sprouts (alfalfa, clover, and radish).
- Unpasteurized or untreated fruit or vegetable juice (These juices will carry a warning label).

Recognizing Foodborne Illness:

- The bacteria in unsafe food is hard to detect. Often the individual cannot see, smell or taste the bacteria.
- Usually, foodborne bacteria take one to three days to cause illness, but you could become sick anytime from twenty minutes to six weeks, depending on the type of bacteria.

- Symptoms of foodborne illness may be confused with other types of illness, but are usually nausea, vomiting, and diarrhea. Or, symptoms could be flu-like with a fever, headache, and body aches.

1. Preparation

a. Cleaning surfaces/dishes/equipment

- Use only clean utensils for tasting food.
- Thoroughly clean all dishes, utensils and work surfaces with soap and water after each use. This procedure is very important after working with raw foods such as meat, poultry, fish or seafood. Take extra precautions by using recommended dilution of bleach solution (1:10) to rinse cutting boards, knives, counter tops, sink, meat grinders, blenders and can openers.
- To sanitize dishes and utensils water must be **at least 170F.**
- If a dishwasher is used, do not open the door to stop the dry cycle. The dry cycle is an effective sanitizer.
- Clean kitchen counters to remove food particles. Sponges used to clean the kitchen where food is prepared should NOT be used to clean up bathroom-type spills. Dirty looking sponges should not be used to wash dishes or clean food preparation areas.
- Sponges used to clean floors or body fluid spills should not be used to wash dishes or clean food preparation areas. Sponges can be disinfected by soaking in a bleach solution (1:10) for five minutes (any longer and the sponges may disintegrate).
- Clean the inside of the refrigerator with soap and water to control molds.
- Mop kitchen floor at least once a week and clean-up spills as they occur. Mop water should not be poured down the sink where food is prepared.

b. Washing/preparing food

Wash your hands in soapy water before preparing food.

Preparing-- If possible, have two cutting boards; one for raw meat, poultry and fish, and the other for vegetable and cooked foods. A hard nonporous (e.g., acrylic) cutting board is better than a wooden one for preventing the spread of bacteria. Thoroughly wash boards with soap and water and rinse with diluted bleach solution. To heat commercially prepared and partially prepared frozen foods, follow package directions. Heating for the specified time ensures that the food is safe to eat.

Preparing vegetables

- Fresh vegetables should be eaten soon after being purchased.
- Vegetables should be washed in running water, but not left to soak.
- Some veggies such as potatoes need scrubbing to remove the dirt. It is better not to peel such vegetables, because nutritional value will be lost.
- Avoid boiling vegetables because nutrients will end up in the water. Instead you can microwave, steam, or stir-fry vegetables in water or a little bit of oil.
- Vegetables should not be overcooked and they should be eaten right away.
- Vegetables should maintain their fresh color, generally, and not end up wet and soggy.

- Frying vegetables (or any other items) can make them taste yummy, but excess oil and calories can be problematic.

c. Defrosting meat

There are three safe methods to thaw frozen meat (the "Thaw Law"):

- Leave it in the refrigerator.
- Place the frozen food in a watertight plastic bag under cold water and change the water often. The cold water temperature slows bacterial growth in the outer, thawed portions of the food while the inner areas are still thawing
- Microwave the meat. Follow the manufacturer's directions.

Caution: It is NOT a safe practice to thaw meat, poultry or fish on the kitchen counter. Bacteria can multiply rapidly at room temperature.

2. Storage

a. Two-hour rule

Chill: Did You Know? At room temperature, bacteria in food can double every 20 minutes.
Harmful bacteria can multiply in the "danger zone" (between 40 and 140 degrees F). So remember the 2-hour rule. *Discard any perishable foods left at room temperature longer than 2 hours*. When temperatures are above 90°F, discard food after 1 hour!

Therefore, the DSP should store leftovers in the refrigerator or freezer immediately after the meal.

Storing meat-- Store fresh or thawed raw meat, poultry and fish in the refrigerator. Put a tray or pan under refrigerated meat, poultry and fish to prevent the juices from dripping onto foods on lower racks. Store cooked meat or poultry products in the freezer if you want to keep them longer than a few days; reheat or thaw for immediate use.

Caution: Do not rely on reheating to make leftovers safe. **Staph** bacteria produces a toxin that is not destroyed by heating.

Canned food-- Commercially canned foods are considered safe because they are processed under carefully controlled conditions. If a commercially canned food shows any sign of spoilage—bulging can, leakage, spurting liquid, off-odor, or mold—throw it out. DO NOT TASTE IT.

Remember: Leftovers need to be thrown out after three days.

b. Refrigerator/freezer temperatures

Refrigerator temperatures should be kept at 40 degrees or less and freezer temperatures should be kept at 0 degrees or less. Check the accuracy with a temperature gauge. Don't rely on the dials on the refrigerator/freezer.

c. Open boxes

Insect and Rodent Droppings and Dirt

- Avoid storing foods in cabinets that are under sinks, drains or water pipes. Openings may be hard to seal adequately and may attract insects and rodents
- Wash the tops of cans and jars with soap and water before opening
- All open containers must be stored in a dated closable container within four hours of opening, stored a minimum of four inches off the floor, and protected from splash and other contamination

REMEMBER

1. Keep food clean
2. Keep hot food hot
3. Keep cold food cold
4. **When in doubt, throw it out**

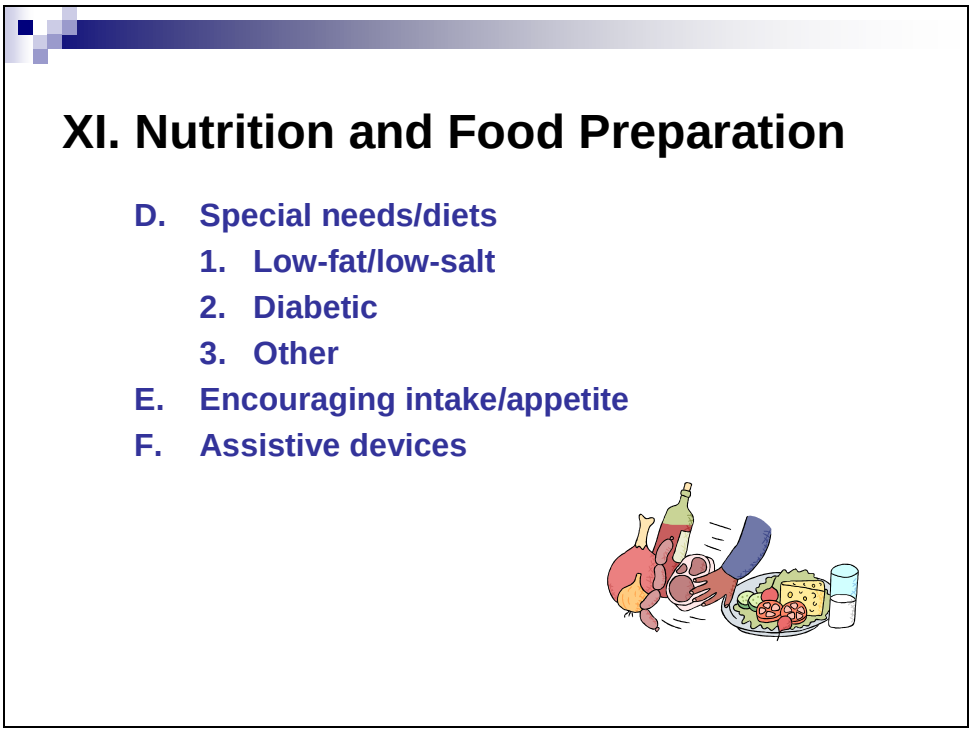
Four Simple Steps to Food Safety

1. **Clean — Wash Hands and Surfaces Often**
   Bacteria can spread throughout the kitchen on cutting boards, utensils, sponges, and counter tops.
   - Wash your hands with hot soapy water before handling food.
   - Wash your cutting boards, dishes, utensils, and counter tops with hot soapy water after preparing each food item and before you go on to the next food.
   - Use plastic or other non-porous cutting boards. Wash cutting boards in hot soapy water or run through the dishwasher after use.
   - Consider using paper towels to clean up kitchen surfaces. If you use cloth towels, wash them often in the hot cycle of your washing machine.

2. **Separate — Don't Cross-Contaminate**
   Cross-contamination is the scientific word for how bacteria can spread from one food product to another. This is especially true when handling raw meat, poultry, and seafood. So keep these foods and their juices away from ready-to-eat foods.
   - Separate raw meat, poultry, and seafood from other foods in your grocery shopping cart and in your refrigerator.
   - If possible, use a different cutting board for raw meat products.
   - Always wash hands, cutting boards, dishes, and utensils with hot soapy water after they come in contact with raw meat, poultry, and seafood.
   - Never place cooked food on a plate that previously held raw meat, poultry, or seafood.

3. **Cook — Cook to Proper Temperature**
   Food safety experts agree that foods are properly cooked when heated for a long enough time and at a high enough temperature to kill the harmful bacteria that cause food borne illness.
   - Use a thermometer, which measures the internal temperature of cooked foods, to make sure meat, poultry, casseroles, and other foods are thoroughly cooked.
   - Cook roasts and steaks to at least 145ºF. Cook whole poultry to 180ºF.
   - Cook ground beef, where bacteria can spread during processing, to at least 160ºF. Do not eat ground beef that is still pink inside.

4. **Chill—Refrigerate Promptly**
   Most bacteria multiply at temperatures between 40º and 140ºF. This is the “danger zone.” Refrigerate foods quickly because cold temperatures keep harmful bacteria from growing and multiplying. Set your refrigerator no higher than 40ºF and the freezer unit at 0ºF. Check these temperatures occasionally with an appliance thermometer. Don’t pack the refrigerator. Cool air must circulate to keep food safe.



D. Special needs/diets

Use fresh foods. Fresh foods have more flavor, color and texture than canned or frozen foods. Additionally, processed, packaged foods often have extra salt, sugar, and/or fat, and may have decreased amounts of vitamins and minerals. Fresh fruits and vegetables that are in season are often less expensive as well.

Prepare cut, chopped, or pureed foods for special diets from the regular menu. In general, a well-balanced meal can be served to all persons including those on diabetic, low-salt, low-fat or other similar special diets.

1. Low-fat/low-salt – a Heart Healthy Diet

Every Day You Should Have:

- 8 to 10 percent of total calories from saturated fat
- 30 percent or less of total calories from fat
- less than 300 milligrams (mg) of dietary cholesterol
- no more than 2400 milligrams (mg) of sodium
- just enough calories to achieve or maintain a healthy weight

To reduce sodium/salt intake in your diet:

- Choose low- or reduced-sodium, or no-salt-added versions of foods and condiments when available.
- Choose fresh, frozen, or canned (low-sodium or no-salt-added) vegetables.
- Use fresh poultry, fish, and lean meat, rather than canned, smoked, or processed types.
- Choose ready-to-eat breakfast cereals that are lower in sodium.
- Limit cured foods (such as bacon and ham); foods packed in brine (such as pickles, pickled vegetables, olives, and sauerkraut); and condiments (such as

mustard, horseradish, ketchup, and barbecue sauce). Limit even lower sodium versions of soy sauce and teriyaki sauce. Treat these condiments sparingly as you do table salt.
- Cook rice, pasta, and hot cereals without salt. Cut back on instant or flavored rice, pasta, and cereal mixes, which usually have added salt.
- Choose "convenience" foods that are lower in sodium. Cut back on frozen dinners, mixed dishes such as pizza, packaged mixes, canned soups or broths, and salad dressings—these often have a lot of sodium.
- Rinse canned foods, such as tuna and canned beans, to remove some of the sodium.
- Use spices instead of salt. In cooking and at the table, flavor foods with herbs, spices, lemon, lime, vinegar, or salt-free seasoning blends. Start by cutting salt in half.

2. Diabetic

There have been many changes recently in diabetic diets. Concentrated sugars such as pies and cakes are no longer taboo. Current diabetic management includes counting carbohydrates. Concentrated sugars can be eaten as long as their portion size and frequency are limited. Diabetics are encouraged to eat a healthy diet of lean meats and fish with fresh fruits and vegetables. Specific dietary guidelines should be obtained from the consumer's physician.

3. Other

Modified - change texture, cut into small bite sizes, or puree foods to accommodate an individual's problems chewing or swallowing. Sometimes a thickener is be added to liquids to help someone eat who chokes on liquids, especially following a stroke.

E. Encouraging intake/appetite – appeal to all the senses

1. Pay attention to the presentation of food.
2. Set the table with tablecloth and/or placemats.
3. Have a meal with a theme such as South of the Border, or Italian with the appropriate food and music.
4. Keep the table conversation positive and pleasant (Never say, "If you don't eat, you won't get dessert!"
5. Make sure eyeglasses are on and clean (Increases appetite when the person is able to see food).
6. May need to increase spices to make food more appealing to compensate for decreased sense of taste and smell.

F. Assistive devices

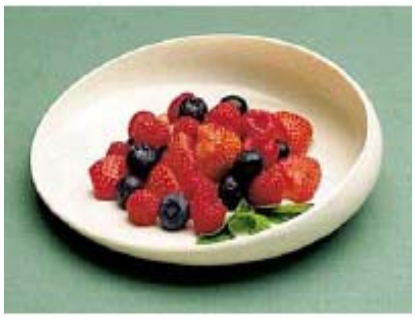
Encouraging a person to eat as independently as possible encourages a person's self sufficiency, self-esteem and can save time. Sometimes a consumer may need to be fed or "guided" through a meal. The following are general considerations:

1. Provide adaptive devices, such as a rocker knife which allows one-handed cutting.
2. Provide foods that do not require use of utensils (e.g., "finger" foods, soup in a mug).
3. Build up handles on utensils to make them easier to grasp.
4. Serve food in bowls with high sides.
5. Keep table setting uncluttered.
6. Use contrasting colors in place setting.
7. Be consistent in placing food on a plate in specific order (and place on table) so, for example, potatoes are at the 3 o'clock position and meat is at the 9 o'clock position (for visually impaired persons).
8. Maintain a simple, consistent, familiar mealtime routine.
9. Maintain a quiet, unrushed atmosphere at mealtime.
10. Serve one course at a time to reduce confusion.
11. For consumers who have had a recent stroke, and are prone to choking, encourage chewing on the unaffected side of his/her mouth. Add a thickener to liquids.

A few examples of assistive devices that are used for eating:

Includes a utensil pocket to keep pencil or eating utensil in place and an elastic strap to keep the unit secured on the hand

Offset spoon and rocker knife for limited hand grasp and dexterity and decreased wrist motion



The scoop dish with a curved side allows you to scoop food more easily…accommodates individuals who have difficulty eating.

Tips for Menus and Shopping

Weekly planning saves time for the DSP and saves money for the consumer (not as much impulse buying). Planning menus with the consumer/family gives control over food preferences and fosters independence.

1. Organize the list into groups found in the same area of the store, such as meat, dairy, etc.
2. Check prices in the newspaper and clip coupons-- read labels and compare store brands
3. Don't buy large quantities if they cannot be stored, handled or used before expiration date.
4. Do not shop sale items if you don't normally use item and cannot store it. **A bargain you can't use is no bargain.**
5. Buy easy-to-prepare foods for times when you are not there to cook. Note special diets.
6. Consider buying smaller portions in the deli instead of preparing large quantities and throwing it away.
7. Consider freezing bread and cheese and take out only the amount that is needed.
8. Eggs have the same nutritional content whether they are jumbo or small, brown or white.
9. Cheaper cuts of meat have same nutritional content—Group beef example.
10. When buying poultry compare prices on parts or whole chicken and decide savings based on how it will be prepared.
11. Consider how much freezer space the consumer has and buy larger quantities to freeze. Wrap individually in freezer wrap before freezing. Be sure to label and date items.
12. Make sure meats and fish are fresh. Look at the color and smell the item.
13. Don't buy damaged canned items.
14. Purchase perishable foods last. Don't let ice cream melt while shopping.

Food Safety Activity

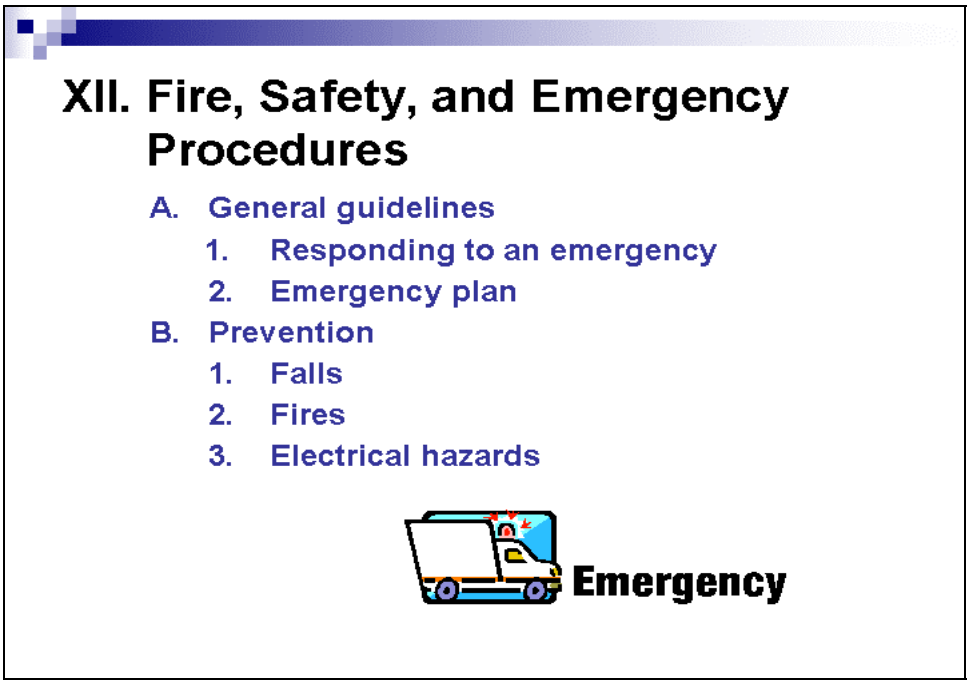
Food Safety Terms Match

Direction: Put the number of the term next to the corresponding definition

Term	Definition
1. Two-hour rule	___ **A.** The transfer of harmful bacteria from one food to another. Harmful bacteria can also be transferred to food from another source, such as hands.
2. Personal hygiene	___ **B.** Defrost foods in the refrigerator, microwave, or in cold water. Never defrost food on the kitchen counter.
3. Bleach solution 1:10	___ **C.** Keeping work areas free from dirt or bacteria.
4. Cross-contamination	___ **D.** An effective sanitizer used to clean kitchen surfaces and cutting boards
5. Contaminated food	___ **F.** Cleanliness, keeping yourself clean.
6. Danger Zone	___ **G.** Perishable food should not be left at room temperature longer than two hours.
7. Food borne illness	___ **H.** Food that contains harmful bacteria.
8. The Thaw Law	___ **I.** Cooking food to a safe internal temperature.
9. Sanitation	___ **J.** Sickness caused by eating contaminated food, sometimes called food poisoning.
10. Thorough cooking	___ **K.** The range of temperatures at which most bacteria multiply rapidly—between 40º and 140º F.

PRINCIPLES OF CAREGIVING

SECTION XII - FIRE, SAFETY, AND EMERGENCY PROCEDURES



A. General guidelines

Why the elderly persons and people with disabilities are more at risk for injuries at home:

1. Living longer may bring more frailty or cognitive impairment.
2. Illness or medications can cause dizziness or unsteadiness.
3. Slower response times, including while driving, can increase accident risk.
4. Decreased mobility makes response times slower.
5. Safety hazards often exist in homes.
6. When elderly or frail individuals are in an accident there is a greater likelihood of being seriously hurt.

1. Responding to an emergency

a. **STAY CALM.** You help the individual just by your calm demeanor in giving reassurance.
b. Yell for someone to assist you if possible.
c. **DO NOT LEAVE** the individual unless it is to call 911 and then return immediately.
d. Keep the individual's airway open.

<u>If the Individual Is Not Responding And Not Breathing:</u>

- Yell for help. Have someone call 911 or you leave the individual momentarily and call 911.
- Don't leave the individual alone except to call for help.
- Begin a CPR assessment and procedure.
- Do not stop CPR until help has arrived!!
- Take medicine or medicine bottles with you to the emergency room.

If the Individual Is Not Responding But Is Breathing:

- Call 911 for emergency assistance.
- Keep the individual's airway open by placing the person on his/her side if possible.
- If you can't get emergency assistance, take the consumer to the nearest emergency center.
- Take medicine or medicine bottles with you to the emergency room.

Call your supervisor after the paramedics have been called and the consumer is no longer in danger.

What To Do If an Individual Falls

- If you are able, when the individual starts to fall, attempt to lower the individual gently to the floor, taking care not to injure yourself in the process.
  - Have the individual lie still while you look for any injuries.
  - If the individual is not complaining of any pain, you may assist the individual in getting up.
    ***Note: Some agencies prefer having the DSP call the Paramedics after every fall; ask your supervisor about agency protocols before going out on assignments.

- If the individual has already fallen when you find him/her or is complaining of pain after falling:
  - Do not move the consumer. Make the person comfortable without moving any affected body parts.
  - Call 911. The Paramedics will evaluate the individual when they arrive.
  - Call your supervisor for any further instructions

If the individual is not responsive, call 911 immediately

For the following First Aid measures:

***Nitroglycerin tablets are taken sublingually (under the tongue)—the individual **must have** a fresh supply of tablets every six months, even if no pills have ever been taken—do not touch pills with your hands as the pills will start to dissolve in the perspiration on your skin—side effects are a pounding headache.

First Aid Chart		
Injury or Emergency	**Symptoms**	**Recommended First Aid Technique**
Anaphylaxis – severe allergic reaction to food, medicine, or insect sting	Swelling of throat, lips, tongue, wheezing, respiratory and cardiac arrest, hives	**Call 911** Initiate CPR assessment and procedure
Breathing stoppage	Look listen and feel for 10 sec and no breathing noted… Bluish gray skin	**Call 911**.Clear the airway if it is blocked. Give two rescue breaths and continue with CPR assessment and procedure
Heart attack-cardiac arrest	No pulse or obvious signs of circulation—bluish gray skin	**Call 911** Begin CPR procedure
Possible heart attack	Heavy pressure mid sternum Pain radiating down left arm, jaw Extreme heart burn	**Call 911** Have person rest, take nitroglycerin tablets as directed if prescribed***
Stroke	Weakness or drooping on one side of the body or face, slurred speech	**Call 911 Critical to have individual seen in ER within 2 hours of onset of symptoms**
Shock	Nausea, low pulse, cool clammy skin, restlessness	**Call 911** Position of comfort, elevate extremities 10 inches, cover with blanket
Bleeding		Use a pressure bandage or direct pressure on wound. Use sterile dressing or clean cloth. Elevate the extremity
Choking	Unable to talk or cough forcefully ***Do not do anything to the individual that is able to cough forcefully	Heimlich Maneuver For infant, turn child upside down on forearm with head pointed down, give 4 back blows between shoulder blades and then four two-fingered thrusts along nipple line, keeping the head pointed down
Poisoning		Call local Poison Control
Burns		Stop the burn by removing the heat source and immerse in or apply cold water …**Do Not Apply** grease or oil
Seizures		Protect from injury… DO NOT RESTRAIN… make sure breathing is restored after the seizure
Fractures	Painful movement, joint deformity	Keep affected area from moving… apply support under and around affected limb with hands and/or clothing. **Call 911**
Heat Exhaustion	Warm, clammy skin, nausea, weakness	**If the person is unresponsive, Call 911** If individual is conscious give fluids and salt
Heat Stroke	Hot, dry skin, elevated body temp, rapid pulse, disorientation	**Call 911** ***First and foremost, cool the victim.*** Possibly spray with a water hose or apply cool towels
Diabetic Emergency	Hypoglycemia—low blood sugar Slurred speech, uncoordinated movements, change in behavior or responsiveness	If person is responsive give sugar, honey, orange juice, soda.. If person is unresponsive squirt sugar (can use tube of cake decorating frosting) inside the mouth. When person comes to, follow with protein snack

2. Emergency plan

Every individual especially if living alone should have an **Emergency Plan** posted in an obvious place such as the refrigerator. The plan should be kept up to date with current medications (recommend attaching it to the back of the plan) in case the individual is unable to give the paramedics the information in an emergency. Below is an example of an Emergency Plan.

**Note Creating/ reviewing an Emergency and Fire Plan would be an excellent activity for the DSP and the consumer.

EMERGENCY PLAN

Name: _____

Address: _____

Phone: _____

Responsible Party/Emergency Contact(s)

Name:_____ Phone(s):_____

Name:_____ Phone(s):_____

911: Fire/Police/Paramedics

Hospital Preference:_____

Physician:_____ Phone: _____

Allergies:_____

Living Will: □ Yes □ No
CPR: □Yes □No (If No, my orange form is located (where):_____)

My Current Medication List Is Located (where): _____

Comments:

_____

_____

Signature: _____ Date:_____

B. Prevention

1. Falls

How serious is the problem?

- More than one-third of adults ages 65 years and older fall each year (Hornbrook 1994; Hausdorff 2001).
- Among older adults, falls are the leading cause of injury deaths (Murphy 2000) and the most common cause of nonfatal injuries and hospital admissions for trauma (Alexander 1992).
- In 2003 more than 1.8 million seniors age 65 and older were treated in emergency departments for fall-related injuries and more than 421,000 were hospitalized (CDC 2005).

What outcomes are linked to falls?

- In 2002, nearly 13,000 people ages 65 and older died from fall-related injuries (CDC 2004). More than 60% of people who die from falls are 75 and older (Murphy 2000).
- Of those who fall, 20% to 30% suffer moderate to severe injuries such as hip fractures or head traumas that reduce mobility and independence, and increase the risk of premature death (Sterling 2001).
- Among people ages 75 years and older, those who fall are four to five times more likely to be admitted to a long-term care facility for a year or longer (Donald 1999).
- Falls are a leading cause of traumatic brain injuries (Jager 2000).

Who is at risk?

- White men have the highest fall-related death rates, followed by white women, black men, and black women (CDC 2004).
- Women sustain about 80% of all hip fractures (Stevens 2000).
- Among both sexes, hip fracture rates increase exponentially with age (Samelson 2002). People ages 85 years and older are 10 to15 times more likely to sustain hip fractures than are people ages 60 to 65. (Scott 1990).

How can seniors reduce their risk of falling?

Through careful scientific studies, researchers have identified a number of modifiable risk factors:

- Lower body weakness (Graafmans 1996)
- Problems with walking and balance (Graafmans 1996; AGS 2001)
- Taking four or more medications or any psychoactive medications (Tinetti 1989; Ray 1990; Lord 1993; Cumming 1998).

Seniors can modify these risk factors by:

- Increasing lower body strength and improving balance through regular physical activity (Judge 1993; Lord 1993; Campbell 1999). Tai Chi is one type of exercise program that has been shown to be very effective (Wolf 1996; Li 2005).

- Asking their doctor or pharmacist to review all their medicines (both prescription and over-the-counter) to reduce side effects and interactions. It may be possible to reduce the number of medications used, **particularly tranquilizers, sleeping pills, and anti-anxiety drugs (Ray 1990). This includes Benedryl.**

Strong studies have shown that some other important fall risk factors are Parkinson's Disease, history of stroke, arthritis (Dolinis 1997), cognitive impairment (Tromp 2001), and visual impairments (Dolinis 1997; Ivers 1998; Lord 2001). To reduce these risks, seniors should see a health care provider regularly for chronic conditions and have an eye doctor check their vision at least once a year.

What other things may help reduce fall risk?

Because seniors spend most of their time at home, one-half to two-thirds of all falls occur in or around the home (Nevitt 1989; Wilkins 1999). Most fall injuries are caused by falls on the same level (not from falling down stairs) and from a standing height (for example, by tripping while walking) (Ellis 2001). Therefore, it makes sense to reduce home hazards and make living areas safer.

- Researchers have found that simply modifying the home does not reduce falls. However, environmental risk factors may contribute to about half of all home falls (Nevitt 1989).
- Common environmental fall hazards include tripping hazards, lack of stair railings or grab bars, slippery surfaces, unstable furniture, and poor lighting (Northridge 1995; Connell 1996; Gill 1999).

To make living areas safer, seniors and people with disabilities should:

- Remove tripping hazards such as throw rugs and clutter in walkways.
- Use non-slip mats in the bathtub and on shower floors.
- Have grab bars put in next to the toilet and in the tub or shower.
- Have handrails put in on both sides of stairways.
- Improve lighting throughout the home.
- **Have telephone within reach of the bed for emergencies.**

Information adapted from the CDC Website: http://www.cdc.gov/ncipc/factsheets/falls.htm

2. Fire Prevention

Cooking

a. Never leave the stove unattended while cooking.
b. If you need to step away from the stove, turn it off or carry a large spoon with you to remind you that food is on the stove.
c. Wear tight-fitting clothing when cooking over an open flame, and keep towels and potholders away from the flame.
d. If food or grease catches fire, smother the flames by sliding a lid over the pan and turning off the heat. **Do not try to use water to extinguish a grease fire**.
e. When deep-frying, never fill the pan more than one-third full of oil or fat.
f. Never put foil or other metals in the microwave.
g. Make sure the stove is kept clean and free of grease buildup.
h. Turn pot handles away from the front of the stove so they cannot be knocked off or pulled down.

Smoking

a. **Never smoke in bed and make sure that you are alert when you smoke**.
b. If a gas stove or oxygen source is nearby, do not smoke.
c. Do not smoke while under the influence of alcohol or if you are taking prescription drugs that can cause drowsiness or confusion.
d. Never leave smoking materials unattended, and collect them in large, deep ashtrays. Soak the ashes in the ashtray before discarding them.
e. Check around furniture, especially upholstered furniture, for any discarded or smoldering smoking materials.

Heating

a. Make sure kerosene heaters are never run on gasoline or any substitute fuel. Check for adequate ventilation to avoid the danger of carbon monoxide poisoning.
b. Have your heating systems and chimneys checked and cleaned annually by a professional.
c. Never store fuel for heating equipment in the home. Keep it outside or in a detached storage shed.

Fireplaces

a. Open fireplaces can be hazardous; they should be covered with tempered glass doors and guarded by a raised hearth 9 to 18 inches high.

3. Electrical Safety

a. Electric blankets or heating pads should conform to the appropriate standards and have overheating protection.
b. Do not wash blankets repeatedly as this can damage their electrical circuitry.
c. If an appliance begins to smell suspicious or emit smoke, unplug it immediately.
d. Replace all frayed or broken electrical cords.
e. Never use an appliance with exposed wires.
f. Never overload extension cords or outlets. Keep extension cords out of traffic areas.

g. Use only tested and UL-listed electrical appliances.
h. Consider using new heat generating pads or blankets in place of electric ones.
i. Never fall asleep with the heating pad on.

Space Heaters

a. Give space heaters space. Keep heaters at least 3 feet from any combustible material, including people.
b. Follow the manufacturers' directions regarding operation, fueling, and maintenance of your space heater.
c. Do not use heaters or other heating devices to dry clothing.

If the individual is on oxygen follow Oxygen Precautions:

- ***Liter flow important; requires a physician order to change just like medications***
- Oxygen should not be flowing near open flames or a heat source
  - Consumer should not smoke with tubing in place and oxygen on
  - Oxygen equipment and tubing should be at least 3 ft from space heater
- Place signs stating that oxygen is in use and warning visitors to refrain from smoking
- Follow tubing care and cleansing guidelines from O_2 company
- E-tank care
- Secure tanks so they cannot be knocked over or be bumped into (strap to a closet wall)
  - Secure in upright position in back seat of a car (in an accident if valve is damaged, the tank can act like a torpedo)
  - Check if valve registers are full and have back-ups

For More Information visit the USFA website:
www.usfa.fema.gov

Responding to a fire

U.S. Consumer Product Safety Commission has targeted these principal consumer products associated with fires:

- Home heating devices
- Upholstered furniture
- Bedding
- Cigarette lighters
- Matches
- Wearing apparel

The Three Key Elements of a Fire

Oxygen- always present in the atmosphere

Heat- present in sources such as heaters, stoves, appliances, electrical connections, fireplaces and lighted cigarettes

Fuel- anything combustible (will burn when exposed to heat) such as cloth, paper, wood, upholstery, and gasoline

A fire needs all three elements to continue to burn. To extinguish a fire you need to take at least one of the elements away.

Fire Extinguishers

Fire extinguishers are categorized by the type of fire they put out (Class A, B, or C fires). If only one extinguisher is available, make sure that it is an ABC fire extinguisher type so that it will put out all three classes of fires.

IF YOU FIGHT A FIRE, REMEMBER THE WORD PASS...

PULL... AIM... SQUEEZE... SWEEP...

Pull -- Place the extinguisher on the floor. Hold it by the tank (pressure on the handle could pinch the pin). Pull the pin straight out.
Aim-- Start 10 feet back from the fire. Aim at the base of the fire.
Squeeze-- Squeeze the lever on the fire extinguisher.
Sweep-- Sweep from side to side, moving in slowly until the fire is out.
Get Out-- If the fire gets bigger, close the door and evacuate.

WHEN NOT TO FIGHT A FIRE...

If the fire is spreading too quickly!
If the fire could block your only exit!
If the type or size of the extinguisher is wrong!
If the fire is too large!
If you don't know how to use your fire extinguisher!

IF ANY OF THE ABOVE CONDITIONS EXIST, LEAVE IMMEDIATELY!!!

KEEP YOURSELF SAFE!!!!

Safety Tips For The DSP

1. Before leaving your home, know how to change a tire and take emergency supplies with you. Always use reliable transportation that is well-fueled.

2. Always inform your office regarding the address you are visiting and the anticipated length of time you will be there.

3. Alert the consumer (when possible) that you are coming and have him or her watch for you.

4. Have accurate directions to the street, building, or apartment. Obtain a map to identify the location to which you are traveling.

5. Drive with the windows closed and all car doors locked. Keep your purse or wallet in the trunk.

6. As you approach your destination, carefully observe your surroundings. Note location and activity of the people; types and locations of cars; conditions of buildings (abandoned or heavily congested buildings).

7. If you see a gathering of people, do not walk through them. Walk on the other side of the street.

8. Before getting out of the car, once again thoroughly check the surroundings. If you feel uneasy, do not get out of the car and notify your office

9. Park your car in a well lit, heavily traveled area of the street. Lock your car and lock your personal items in the trunk.

10. Do not enter the home if the situation seems questionable (e.g. drunk family members, family quarrel, combativeness, unleashed pets, etc). **If your instinct tells you to leave, you may want to say, "I am leaving now. I forgot I have another appointment." You should call 911 if in danger or a medical emergency presents. Never try to take care of this situation on your own!**

11. Note your exits when you enter a consumer's residence. Try to always have a safe way out.

12. You should remain cautious when approaching pets within the home/community setting. They may be territorial and protective of their owners. It may be necessary to ask a family member to confine them briefly while you are completing your assessment and/or visit.

1. **Be Alert**
2. **Be Observant**
3. **Trust Your Own Instincts**
4. **Know How And When To Call 911**

Activity: What Would You Do?

Break into groups—Review the situation and decide the course of action

A 911: Call 911 and then call your supervisor as soon as possible
B Call Supervisor

Situations: Put the letter of the action above next to the situation

1. ___ Onset of fever of 101 degrees or higher
2. ___ New or sudden onset of incontinence
3. ___ Rash lasting several days or getting worse
4. ___ Bleeding that cannot be controlled
5. ___ Severe sore throat/difficulty swallowing
6. ___ Infection at injury site
7. ___ Unusual difficulty in arousing
8. ___ Scratching/holding one or both ears
9. ___ Diarrhea or vomiting lasting more than four hours
10. ___ Has a seizure lasting 5 minutes or continuous seizures, paralysis, confusion
11. ___ Onset of limping, inability to walk, or difficulty in movement
12. ___ Intense itching with no other symptoms
13. ___ Has trouble breathing or is breathing in a strange way
14. ___ Is or becomes unconscious not related to seizure
15. ___ Has no pulse
16. ___ Has symptoms of pain or discomfort
17. ___ Has chest pain or pressure
18. ___ Severe injuries as a result of accidents such as broken bones
19. ___ Has injuries to the head, neck, or back
20. ___ Has gone into shock

Answers

1. **B** Onset of fever of 101 degrees or higher
2. **B** New or sudden onset of incontinence
3. **B** Rash lasting several days or getting worse
4. **A** Bleeding that cannot be controlled
5. **B** Severe sore throat/difficulty swallowing
6. **B** Infection at injury site
7. **A** Unusual difficulty in arousing
8. **B** Scratching/holding one or both ears
9. **B** Diarrhea or vomiting lasting more than four hours
10. **A** Has a seizure lasting 5 minutes or continuous seizures, paralysis, confusion
11. **A** Onset of limping, inability to walk, or difficulty in movement
12. **B** Intense itching with no other symptoms
13. **A** Has trouble breathing or is breathing in a strange way
14. **A** Is or becomes unconscious not related to seizure
15. **A** Has no pulse
16. **B** Has symptoms of pain or discomfort
17. **A** Has chest pain or pressure
18. **A** Severe injuries as a result of accidents such as broken bones
19. **A** Has injuries to the head, neck, or back
20. **A** Has gone into shock

Optional Resources:

Fire Safety Preparedness for those with Mobility Impairments

Identify the Nearest Emergency Exit

- Whether at home or elsewhere, you should always know the location of the nearest exit. This could save your life in an emergency.

Heed Fire Safety and Design Guidelines

- Walkways and doorways should accommodate any mobility impairment the individual may have.
- Doorways should accommodate a wheelchair's width, and flooring material should accommodate artificial limbs or canes.

Install Smoke Alarms

The single most important step you can take to save your life during a fire is to install a smoke alarm that suits your needs. A properly functioning alarm can alert you to the presence of deadly smoke while there is still time to escape and **may reduce the risk of dying in a fire by as much as 60 percent.**

- Place alarms next to each sleeping area and on every floor of your home.
- Keep smoke alarms clean by vacuuming or having them vacuumed regularly.
- Test batteries monthly, and replace them semi-annually (when daylight savings time changes).
- Ask friends, family members, building managers, or a caregiver to install and test the batteries of a smoke alarm if it is hard to reach. If your smoke alarms are hard-wired (connected to the electric circuitry of your residence), make sure they are also equipped with battery backups.
- Use smoke alarms with a strobe light or vibrator for hearing impaired individuals.

Have a Fire Extinguisher—and Learn How To Use It (See Previous Material)

- Keep a portable fire extinguisher in the kitchen and any other room at risk for fire.
- If you are a wheelchair user, consider mounting (or having someone mount) a small "personal use" fire extinguisher in an accessible place on your wheelchair, and become familiar with its use. Then, if you cannot "stop, drop, and roll" during a fire, you should "pull, aim, squeeze, and sweep."

Live or Sleep Near an Exit

- If you live in an apartment building, try to get an apartment on the ground floor. If this is not possible, know where the exit stairwell is and plan to wait there for help if you cannot take the stairs in the event of a fire.
- If you live in a multi-story house, try to sleep on the ground floor.

- Make sure a phone is next to your bed, within arm's reach, and emergency telephone numbers written in large, bold print readily accessible. Keep a working flashlight in every bedroom since smoke creates darkness and the electricity may go off.
- If necessary, construct an exit ramp for emergency exits. It is recommended that ramps be at least 36 inches wide. Guardrails and handrails should be 44 to 48 inches high and 34 to 38 inches wide.

Plan and Practice Escape Plans

Fire is fast. In less than 30 seconds, a small fire can blaze out of control. In less than five minutes, a home can be consumed in flames. Knowing your escape plan is one of the most important steps you can take to save your life.

- Plan your escape around your capabilities. Practice the plan when blindfolded or in darkness. Most fire deaths occur between 2am and 6am.
- Know at least two exits from every room. Make sure you can unlock all your doors and windows.
- Keep escape routes such as hallways, stairways, and doorways clear and free of clutter.
- Be sure you know how to open your windows. If security devices, such as bars, are installed across the windows, ensure that they release from the inside.
- Have a prearranged spot to meet outside the home such as a tree or spot on the sidewalk.
- Make any necessary accommodations (such as installation of exit ramps) to facilitate an emergency escape.

Involve the Fire Department

- Ask the fire department to help you plan an escape route, and inform them of your special needs.
- Ask the fire department to help identify any fire hazards in your home and explain how to correct them. Any areas you plan to use as a rescue area must be identified and agreed upon by you and officials from the fire department.
- Learn the fire department's limitations, and make fire officials aware of yours.

<u>During the Fire</u>

Get Out and Stay Out

- Leave your home as soon as possible.
- Do not try to gather personal possessions or attempt to extinguish a fire.
- Do not use the elevator.
- Once out, do not go back inside. Call the fire department from a neighbor's home. Tell them if someone is missing. They are trained to perform safe rescues.

Test the Doors Before Opening Them

- Using the back of your hand, reach up high and touch the door, the doorknob, and the space between the door and the frame.
- If anything feels hot, keep the door shut and use your second exit.
- If everything feels cool, open the door slowly and exit as low to the ground as possible if smoke is present.

Stay Low and Leave Quickly

Heat is more threatening than flames. Since heat rises, it can be 100 degrees at floor level and **600 degrees at eye level.** Be careful of poisonous gases. Fire eats up oxygen. Breathing in even small amounts of toxic gases and smoke can make you drowsy and disoriented. Fumes can lull you to sleep before the flames reach you (another reason why you should have a smoke alarm).

- Crawl low and keep under the smoke, if you are physically able.
- If not, try to cover your mouth and nose to avoid breathing toxic fumes, and make your way to safety as quickly as possible.

What To Do If You Are Trapped

- Close all the doors between you and the fire.
- Fill cracks in doors and cover all vents with a damp cloth to keep smoke out.
- If possible, call the fire department and tell them where you are located.
- Signal rescuers from a window with a light-colored cloth.

Stop, Drop, and Roll

- If any part of you catches fire, do not run and do not try to extinguish the flames with your hands.
- Cover your face with your hands.
- Drop to the ground, rolling over and over.
- If you have a disability that prevents your taking these actions, try to keep a flame-resistant blanket or rug nearby to smother any flames. You can also attach a fire extinguisher to your wheelchair.

Fire Safety information for at risk populations can be found at:
http://www.usfa.dhs.gov/safety/atrisk/disabilities
Information is public domain

Additional Resources:

For More Information visit the USFA website: www.usfa.fema.gov

PRINCIPLES OF CAREGIVING

SECTION XIII - HOME ENVIRONMENT MAINTENANCE

XIII. Home Environment Maintenance

A. Care/support plans
B. Supplies
C. Planning and organizing tasks
D. Cleaning
E. Laundry
F. Bed making
G. Issues
   1. Cultural
   2. Religious
   3. Consumer rights
H. Other

A. Care/support plans

1. The care/support plan usually lists generalities such as clean the kitchen or wash clothes. It does not list the procedures—that is up to the DSP and the consumer
2. FOLLOW THE CARE/SUPPORT PLAN – If a consumer wants you to deviate from the plan, you need to contact your supervisor. **YOU MAY BE HELD LIABLE IF YOU DO SOMETHING FOR THE CONSUMER THAT IS NOT ON THE CARE PLAN AND AN ACCIDENT OCCURS.**
3. Make a list of tasks that need to be done according to the care plan.
4. Ask the consumer to prioritize the tasks that need to be done – If the consumer lists more tasks than what can be accomplished in your allotted time, try to negotiate with the individual to do it another day.

B. Supplies

1. Maintain list of items in short supply.
2. Have a shopping list posted on the refrigerator door for the consumer and family members to use.
3. When using cleaning products or appliances, read labels and directions carefully.
4. If equipment is faulty, notify consumer and/or supervisor.
5. **Be considerate of the consumer's financial resources and buy/use cleaning supplies frugally.**

C. Planning and organizing tasks

1. Follow the consumer's directions when performing tasks, even if you know a better way.
2. Plans may also change depending on the consumer's needs or health status.
3. Use a tray to carry dishes to and from the table.
4. Carry cleaning supplies from room to room in a shopping bag or basket (keep a small plastic bag for trash with you while cleaning—saves steps to the trash can).

5. Sample plan;
   A load of laundry can be put in the machine just before lunch. While the machine is running, prepare and serve lunch to consumer. Dry and fold clothes while consumer is resting after lunch.

D. Cleaning

1. Cleaning Appliances
   a. Dishwasher – Clean exterior and interior
   b. Freezer – Defrost once a year. Wipe inner surface with a damp cloth. Check outdated food and dispose of food with the consumer's permission.
   c. Refrigerator – Clean inside and outside with soft wet cloth and mild soap or backing soda. Check for spoiled food and dispose of food with the consumer's permission.
   d. Trash Compactor – Replace bags as needed.
   e. Garbage Disposal – Run cold water during use and for one minute after. Oranges, lemons, and ice can be used to maintain freshness.
   f. Microwave Oven – Wipe with wet cloth and soap. Rinse and wipe dry.
   g. Stove/Oven – Wipe up spills and grease immediately! Clean oven with vinegar in water to remove grit.
   h. Washing Machine – Wipe exterior and interior with soft wet cloth. Clean lint filter.
   i. Dryer – Clean filter because heavy buildup of lint can catch fire.

2. Cleaning Tasks
   a. Dishwashing-- Hand wash dishes in the following order:
      - Glasses
      - Silverware
      - Plates and cups
      - Pots and pans
      - Rinse with hot water and allow to AIR DRY
   b. Dishwasher
      - Run only full loads to conserve water, soap and power costs
      - Do not interrupt the dry cycle to save money if sanitizing the dishes is needed
   c. Cleaning Bathroom
      - Wear gloves
      - Clean from cleanest areas to dirtiest (toilet is considered the dirtiest)
      - Clean sink, countertops, and shower/tub with disinfectant (bleach solution 1:10 works well)
      - Use a brush to clean the toilet, and brush under the rim
      - DO NOT COMBINE cleaning chemicals especially AMMONIA AND BLEACH as this forms a toxic gas!
   d. Floors
      - Use a clean mop and change mop water when dirty.
      - Vinyl: use mild soap and rinse with clean warm water.
      - Ceramic floors: use vinegar and water. Check with consumer if soap can be used.
      - Carpets: Vacuum frequently making sure the bag does not get overfilled. To remove stains Hot Shot carpet stain remover works well.
   e. Daily cleaning tasks
      - Pick up toys, magazines, newspapers, etc., especially if in the walkway

- Make beds.
- Empty wastebaskets and take out trash
- Do dishes and wipe off counters
- Clean top of the stove
- Sweep kitchen

f. Weekly cleaning Tasks
- Change bed linens
- Dust furniture
- Clean shower and tub
- Clean switch plates
- Clean mirrors
- Clean TV
- Vacuum floors and carpets
- Mop floors
- Water plants

g. Periodic Cleaning
- Remove cobwebs from ceilings, walls, and drapes
- Clean window blinds
- Clean picture frames
- Clean lamps
- Clean inside windows
- Straighten drawers and closets
- Clean ceiling fans
- Launder throw rugs, or get rid of them (after getting consumer's permission)

E. Laundry

1. Check labels for special washing instructions.
2. Check the clothes for stains and pre-treat.
3. Turn dark clothes, beaded, or appliquéd garments inside out.
4. Take care when washing red or vibrant colors ** Shout's "Color Catcher" sheets or like product works great to pick up any excess dye in the wash water. Can be re-used a couple of times depending on how much dye residue is in the sheet.
5. Check the pockets.
6. Sort clothes by colors (whites and colors), lint generators such as towels, lint magnets (corduroy), and delicates.
7. Zip pants and skirts.
8. Use liquid bleach only for white cotton materials.
9. Do not overload the washer as this decreases the agitation and cleaning power.
10. Distribute clothes evenly in the wash drum.
11. Dryer use
    a. Do not put delicates in the dryer unless directed by the consumer.
    b. Remove clothes when dry immediately and hang up or fold.
    c. Some permanent press clothes will be less wrinkled if taken out of the dryer while still slightly damp and hung on a hanger.
    d. Clean lint filter after every load.

F. Bed making

1. Place clean linens near the bed.
2. Strip the bed gently to avoid spreading pathogens into the air. Fold blanket(s) and place nearby. Place linens to be washed in a plastic bag or hamper.
3. Open sheets gently. Do not shake.
4. Put the contour sheet or flat sheet at the head of the bed working toward the bottom. Only work on one side at a time to save time and energy.
5. Miter the corners (square off the corners) and tuck the sheet under.
6. Place top sheet over the clean bottom sheet wrong side up with the top edge of the hem even with the top edge of the mattress.
7. Place any blanket(s) back on the bed with the top edge of the blanket(s) about 12 inches from the top of the mattress.
8. Tuck both the top sheet and blanket(s) under the mattress and miter the corners.
9. Repeat procedure on the other side of the bed.
10. Place blanket with top at bed head and extend to foot.
11. Remove surface winkles.
12. Fold excess top sheet over top of blanket and cover with spread if desired.
13. Put clean pillowcases on pillows. Arrange side by side on top of folded top sheet.
14. Take soiled linens to bathroom or laundry.
15. If you have linens that are soiled with body fluids(feces, urine, vomit):
    a. Put on gloves before handling soiled linens and carry at arms length (not against your clothing).
    b. Put linens in a plastic bag (NOT THE FLOOR) and take them to the bathroom.
    c. Rinse the “chunky stuff” out in the toilet and place the soiled linens back in the plastic bag.
    d. Launder immediately using bleach if linens are white. If the sheets are colored just make sure they are dried completely in the dryer (the heat is as effective as bleach in killing the bacteria).

G. Issues

Be aware of the following issues that may affect how and what you clean

1. **Cultural**
   Culture affects a person’s belief in how things are treated (i.e. money, time, animals)
2. **Religious**
   Religious beliefs affect holiday observations, cooking, and cleaning and handling of religious artifacts
3. **Consumer rights**
   a. Adapt to consumer’s household. Use the consumer’s equipment and cleaning supplies.
   b. Be considerate and cautious of consumer’s supplies, equipment, and furnishings. Conserve whenever possible.
   c. Show as much respect for the consumer’s property as you would if it were your own.

Activity

Break into groups and discuss the following scenario:

You are assigned to provide eight hours of housekeeping and personal care services for an incontinent consumer. When you arrive you encounter piles of laundry, dirty floors, soiled bed linens, dirty dishes in the sink, and no food in the refrigerator. The consumer needs a bath and is hungry but wants to go for a walk in the park. How would you respond to the consumer's request? How would you organize and prioritize the other chores on your care plan?

What would you do if you only had three hours scheduled?

PRINCIPLES OF CAREGIVING

SECTION XIV - ACTIVITY PLANNING

XIV. Activity Planning

- A. Principles and purposes
- B. Sample activities
- C. Issues
  - 1. Cultural
  - 2. Religious
  - 3. Consumer rights
- D. Resources
  - 1. Web sites
  - 2. Agencies
  - 3. Other

A. Principles and purposes

1. Activities should be geared to the functional status of the individual to reduce depression, stress, and anxiety; to help the individual recover basic motor functioning and reasoning abilities; to build confidence; and to socialize effectively in order to enjoy greater independence.
2. Activities can reduce or eliminate the effects of illness or disability and help to integrate people into the community by teaching them how to use community resources and recreational activities.
3. Consider activities such as walking, water workouts or Tai Chi — a gentle exercise that involves slow and graceful dance-like movements. Such activities reduce the risk of falls by improving strength, balance, coordination and flexibility. Avoiding exercise because of fear will make a fall more likely.
4. Before beginning any exercise program the consumer should consult with a health care provider for an individualized plan.

The purposes of activities

1. To maintain sense of self
2. To enhance the consumer's quality of life
3. To maintain connection with the outside world
4. To encourage socialization
5. To help the consumer maintain whatever strengths they may have for as long as possible

6. To make the consumer feel useful in some way

7. To encourage independence

8. To increase self-esteem

9. To encourage expression of feelings

10. To provide intellectual stimulation

11. To maintain physical well-being

12. To entertain the consumer

13. To bring some fun into a boring day

14. To alleviate the family concern regarding the consumer "not doing enough."

15. To decrease consumer agitation. Keeping the consumer busy may diminish restlessness and sleeplessness associated with certain illnesses.

The DSP should not think of activities as doing something with the consumer at a specific time. Think of incorporating strengthening or sensory stimulation activities into regular personal care activities.

For example, assisting with bathing is <u>an activity.</u> The DSP could play music and sing to/with the individual during bathing. Not only is it a great distracter but it is also an opportunity to connect with the consumer.

Play music according to the consumer's preferences (brush up on your "oldies but goodies" such as "Daisy" and "How Much is that Doggy in the Window"). Some consumers prefer some of the old gospel classics like "Rock of Ages" or "This Little Light of Mine". The consumer will not mind if you do not have a perfect voice and the two of you can laugh at forgotten words or have the consumer fill in some of the words for you.

Another example is foot massages with aromatic lotions. It accomplishes not only a sensory simulating activity but it also allows the DSP to examine the consumer's feet for any skin changes.

B. Examples of activities specific to various disabilities

General activities	Dementia, Stroke	Muscle strengthening exercises for w/c users	COPD (Chronic Obstructive Pulmonary Disease)
Try to appeal to hobbies and interests	Appeal to senses—color, shape, texture, scents	Exercises aimed at increasing upper arm strength	Start slowly and gradually—take breaks as needed
Playing checkers or other board games	Read a story or newspaper	Bicep curls	Short walks
Play cards	Review family snapshots	Seated push-ups	Yoga
Write a personal history	Go for a walk	Weight lifting	Dancing
Go for a walk	Listen to music	Play a tape of yoga/ Tai Chi	Stationary bike
Write a letter	Sing Christmas or spiritual songs	Exercise lower extremities using stretchy bands (Thera-band)	Exercise upper and lower extremities using stretchy bands (Thera-band)
Make a craft/holiday decorations	Give a manicure/pedicure		
Swim	Massage w/ aromatherapy lotion		
Watch/discuss a movie	Reminisce		
Plan meal, make grocery list, clip coupons	Make a grocery list and discuss prices then and now		
Cooking	Folding towels		

C. Issues

1. **Cultural**
   Look to the consumer's cultural and ethnic background for possible activities—Ask the family what the consumer has enjoyed or been involved with in the past. Music is an important part of most cultures. Determine from the consumer /family what kinds of music the consumer prefers.

2. **Religious**
   Religious and spirituality activities play a significant role in providing meaning and shaping the purpose in life with many people. However the DSP must be very sensitive to the religious beliefs of the consumer and not try to convert the consumer to the DSPs viewpoints. Again, religious music may play an important part of the consumer's life. As was stated above determine from the consumer /family what kinds of music the consumer prefers.

3. **Consumer rights**
   The consumer has the right to refuse activities—try to find activities that interest the consumer, not just those that interest you.

D. Resources

1. Web sites

- http://www.recreationtherapy.com/tractv.htm
- http://www.aarp.org/fun/humor/

2. Agencies

- **Local parks and recreation for Senior Centers and subsidized lunch sites**
- **Area Agency on Aging Information and Referral**
- **The Alzheimer's Association**

3. Other

Scenario:

You are assigned to a female consumer who has a severe form of arthritis. The physical therapist has developed a care plan for the consumer. However, when you ask her about it, she tells you "it hurts too much to exercise." What three steps could you take to ensure that the consumer completes the exercise plan?

Activity

1. Divide class into groups.
2. Distribute a sheet of paper to each group with a list of three examples of your agency's consumers such as an individual with advanced Alzheimer's, a wheelchair user who needs to strengthen upper arms, a child with cerebral palsy, etc.
3. Have each group decide on an appropriate activity for each consumer based the consumer's needs, functional status, and cultural/ethnic background and the supplies that will needed for each activity.
4. Then have each group share the activities they chose with the large group.
5. Discuss what other activities might be good and what activities might not be good.

Examples of possible consumers:

An individual with advanced Alzheimer's disease who is Jewish

A young adult who is a wheelchair user who used to run marathons

A person who has had a recent stroke and is having difficulty talking